

Rhode Island

UNIFORM APPLICATION

FY 2025 SUPTRS Block Grant Report

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 03/02/2022 - Expires 03/31/2025
(generated on 12/02/2024 1.15.13 PM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

I: State Information

State Information

I. State Agency for the Block Grant

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III. Expenditure Period

State Expenditure Period

From 7/1/2023
To 6/30/2024

Block Grant Expenditure Period

From 10/1/2021
To 9/30/2023

IV. Date Submitted

Submission Date 12/2/2024 1:11:59 PM
Revision Date 12/2/2024 1:12:49 PM

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Footnotes:

II: Annual Update

Table 1 Priority Area and Annual Performance Indicators - Progress Report

Priority #: 1
Priority Area: Youth
Priority Type:
Population(s): PP

Goal of the priority area:

Reduce youth (ages 12-17) use, misuse, and abuse of alcohol, marijuana, prescription drugs, and tobacco-related products including use of electronic nicotine delivery system products (ENDS).

Objective:

Reduce the use of substances that negatively affect the development of youth.

Strategies to attain the goal:

The evidence-based program, Project SUCCESS, in junior high/middle schools and high schools in more than 35 school districts statewide. Project Success includes programming directed at the entire school population (universal indirect); education for an entire grade of students (universal direct); and interventions for students at high risk for substance use (selected and/or indicated). Implementation of the six CSAP strategies by the state's seven regional prevention task forces which include regional coalitions working within their communities.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Reduce the percentage of youth ages 12-17 reporting 30-day use of alcohol, marijuana, prescription drugs, and electronic nicotine delivery system products (ENDS)
Baseline Measurement: 30 -day use of marijuana: 9.5%;; 30- day use of alcohol: 9.0%; 30-day use of e-cigarettes 9.1%; 30-day non-medical use of prescription medication 2.0%
First-year target/outcome measurement: Maintain the percentages of 30 day use of alcohol, marijuana, prescription drugs,, and ENDS products by junior high/middle school and high school students in municipalities across the state.
Second-year target/outcome measurement: One percentage point decrease in reported 30-day use of alcohol, marijuana, and ENDS products and continue to maintain percentage for prescription drugs by junior high/middle school and high school students in municipalities across the state.

New Second-year target/outcome measurement(if needed):

Data Source:

Rhode Island Student (RISS)

New Data Source(if needed):

Description of Data:

The Rhode Island Student Survey (RISS) is a risk and prevalence survey that is administered biennially in nearly every middle and high school in RI.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target:

Achieved

Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Past 30-day use among 12–17-year-olds from the 2024 RISS:
 Alcohol: 7.0%
 Marijuana: 9.1%
 ENDS: 6.3%
 Rx Drugs: 1.9%

Indicator #:

2

Indicator:

Increase the percentage of youth ages 12-17 reporting perception of risk of harm associated with substance misuse

Baseline Measurement:

Perception of risk of harm for alcohol: 42.3%; Perception of risk of harm for marijuana: 47.7%; Perception of risk of harm for prescription drugs: 74%; and electronic nicotine delivery systems (ENDS) 60.8%

First-year target/outcome measurement:

Maintain the perception of risk of harm for substances (based on baseline)

Second-year target/outcome measurement:

Increase perception of risk of harm for substances by 3% (based on first year target)

New Second-year target/outcome measurement(if needed):

Data Source:

Rhode Island Student Survey

New Data Source(if needed):

Description of Data:

The RI Student Survey (RISS) is a risk and prevalence survey that is administered bi-annually in nearly every middle and high school.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target:

Achieved

Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Perception of risk associated with substance use among 12-17-year-olds from the 2024 RISS:
 Alcohol: 44.8%
 Marijuana: 52.2%
 ENDS: 64.1%

Priority #: 2
Priority Area: Persons Who Inject Drugs
Priority Type:
Population(s): PWID

Goal of the priority area:

Reduce the number of overdose deaths of individuals in RI who inject drugs. Populations to be served include individuals who have overdosed regardless of route of administration.

Objective:

Reduce fatalities.

Strategies to attain the goal:

The State of Rhode Island will continue to provide outreach via the Recovery Community Centers. New this year is the addition of the Hope Initiative and the IMANI Project, which focuses on underserved communities by partnering with faith-based organizations as "safe space" for those who are not comfortable with traditional methods of providing services.

Edit Strategies to attain the objective here:

(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of unique contacts who met with a recovery coach through Anchor's ED program and/or recovery community center ED outreach
Baseline Measurement: 1,364
First-year target/outcome measurement: 1,430
Second-year target/outcome measurement: 1,500

New Second-year target/outcome measurement(if needed):

Data Source:

Recovery Community Center reporting to the BHDDH Contract Monitoring Unit

New Data Source(if needed):

Description of Data:

Our goal is to continue to reach about 100 new individuals each month through this program. Data will be submitted monthly by the Recovery Community Centers, as part of their contracts currently being finalized. It will be aggregated to an annual total for reporting.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

Eventually, this indicator may experience a ceiling effect where there aren't as many unique contacts to work with in this program.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

The outcome was 1408 which is below the target. The reasoning is staffing vacancies along with one of the RCC's does not have a hospital in their catchment area.

How first year target was achieved (optional):

Indicator #:

2

Indicator:

Number of persons who received outreach or contact with a recovery coach through Anchor MORE/recovery community center outreach programs

Baseline Measurement:

37,207

First-year target/outcome measurement:

39,000

Second-year target/outcome measurement:

40,900

New Second-year target/outcome measurement(if needed):

Data Source:

Recovery Community Center reporting to the BHDDH Contract Monitoring Unit

New Data Source(if needed):

Description of Data:

The number of people who received outreach/contact with a Peer Recovery Specialist tends to be higher in summer and spring months versus winter months.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

This may include a duplicate count of people as it's not indicated as a unique count.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target:

Achieved

Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

41,948 people received outreach/contact

Priority #:

3

Priority Area:

Individuals Experiencing Homelessness

Priority Type:

MHS, ESMI, BHCS

Population(s):

SMI

Goal of the priority area:

Ensure individuals receiving services from behavioral health services are being monitored to ensure they remain housed.

Objective:

Stakeholders are reporting evictions of clients receiving services from the mental health continuum of care. The objective is to decrease eviction rates of SMI individuals by ensuring providers are addressing housing instability.

Strategies to attain the goal:

1. Ensure provider reviews "residential arrangement" field in data collection tool (BHOLD).
2. Ensure provider perform Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) to determine service needs.
3. Participate in the chronic homeless housing wait list work group managed through the statewide Continuum of Care.
4. Engage individuals in supportive services.

Edit Strategies to attain the objective here:

(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Persons experiencing SMI who are connected with a mental health provider will remain housed.

Baseline Measurement: 87%

First-year target/outcome measurement: 87%

Second-year target/outcome measurement: 89%

New Second-year target/outcome measurement(if needed):

Data Source:

BHOLD

New Data Source(if needed):

Description of Data:

BHDDH collects data via an electronic system that providers enter data into directly. The BHOLD field "Residential Arrangement" collects data on 12 arrangements. All are considered housed except for "shelter", "homeless" and "unknown". The percentage in these categories will not increase, while the percentages in the housed categories will remain stable or increase.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

Provider agencies will need to be cognizant of the data fields and the need to update. If there is no change in residential arrangement, it is unknown if the provider reviewed housing concerns with the client.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

88% of persons experiencing SMI who are connected with a mental health provider are housed for FY24.

Priority #: 4

Priority Area: Youth and Young Adults Experiencing Early Serious Mental Illness/First Episode Psychosis

Priority Type: MHS, ESMI, BHCS

Population(s): ESMI

Goal of the priority area:

Ensure youth and young adults have access and are receiving behavioral healthcare services.

Objective:

Increase the number of youth and young adults being served in the Healthy Transitions program.

Strategies to attain the goal:

The Healthy Transitions program will provide services to youth and young adults, ages 16 to 25, throughout Rhode Island. Each HT location will provide services to youth and young adults via block grant funds. The block grant funds will be used to provide services to uninsured and underinsured for all ages.

**Edit Strategies to attain the objective here:
(if needed)**

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth and young adults ages 15 through 26 newly enrolled in treatment services through the Healthy Transitions Program.

Baseline Measurement: 100 youth and young adults enrolled in HT

First-year target/outcome measurement: 112 youth and young adults enrolled in HT

Second-year target/outcome measurement: 125 youth and young adults enrolled in HT

New Second-year target/outcome measurement(if needed):

Data Source:

Data is currently being collected through the SAMHSA National Outcome Measures Surveys as well as the Rhode Island Outcomes Questionnaires. Going forward, all sites participating in the Healthy Transitions project will be required to submit data to BHOLD.

New Data Source(if needed):

Description of Data:

All contracts, regardless of discretionary or block grant funding have data reporting requirements that are included in this metric.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

N/A

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Newly enrolled in HT was 115

Priority #: 5

Priority Area: Adults Diagnosed with SMI

Priority Type: MHS, ESMI, BHCS

Population(s): SMI

Goal of the priority area:

Reduce unnecessary hospitalization use by Community Support Programs (CSP) clients.

Objective:

Improve communication and client flow between inpatient and community providers to ensure most appropriate levels of care are provided to stabilize individuals in the community.

Strategies to attain the goal:

System Review by catchment areas with all providers, both inpatient and community to review client flow, processes and barriers to services.

Edit Strategies to attain the objective here:

(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Rate of community support programs (CSP) clients being re-admitted to hospitals within 30 days of previous admission per 1000

Baseline Measurement: 262 readmits per 1,000

First-year target/outcome measurement: Less than 260 readmits per 1,000

Second-year target/outcome measurement: Less than 260 readmits per 1,000

New Second-year target/outcome measurement(if needed):

Data Source:

MMIS

New Data Source(if needed):

Description of Data:

Medicaid claims data for CSP members

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

Data aligns with the MACPRO (CMS) reporting which is based on the Calendar Year.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Reached with 200.4 readmits per 1000.

Indicator #: 2

Indicator: Number of psychiatric admits by CSP clients per 1,000

Baseline Measurement: 108 admissions per 1,000 clients

First-year target/outcome measurement: 105 ER admissions per 1,000 clients

Second-year target/outcome measurement: 105 ER admissions per 1,000 clients

New Second-year target/outcome measurement(if needed):

Data Source:

MMIS

New Data Source(if needed):

Description of Data:

Reporting is calendar year to align with the MACPRO (CMS) reporting.

New Description of Data(if needed)

Data issues/caveats that affect outcome measures:

N/A

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Achieved with 71 admits per 1000

Priority #: 6

Priority Area: Women and children

Priority Type:

Population(s): PWWDC

Goal of the priority area:

To connect pregnant women and women with dependent children with SUD to services.

Objective:

Ensuring pregnant people are screened and offered SUD services.

Strategies to attain the goal:

The Substance Exposed Newborn Program works to improve the health and well-being of pregnant people, children, and families affected by prenatal substance use.

Edit Strategies to attain the objective here:

(if needed)

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator: Number of SEN program participants who accepted and received at least one in-person visit.

Baseline Measurement: 336

First-year target/outcome measurement: 360

Second-year target/outcome measurement: 370

New Second-year target/outcome measurement(if needed):

Data Source:

Program data sent to the program liaison.

New Data Source(if needed):

Description of Data:

Data is submitted to BHDDH staff from the Department of Health on a monthly basis.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

n/a

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

The outcome was 311 which is below the target. The reasoning is that Family Visiting is a voluntary program so, families can accept or decline services. The scope of work and benchmarks will be reassessed upon review of data that was collected the past two years.

How first year target was achieved (optional):

Indicator #: 2

Indicator: Number of SEN program participants for whom First Connections provided care coordination activities.

Baseline Measurement: 156

First-year target/outcome measurement: 165

Second-year target/outcome measurement: 175

New Second-year target/outcome measurement(if needed):

Data Source:

Data submitted to the program liaison.

New Data Source(if needed):

Description of Data:

Data is submitted to BHDDH on a monthly basis from the Department of Health.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

N/A

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target:

Achieved

Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

The outcome was 145 which is below the target. The reasoning is that not all families require care coordination. The family's need is related to level of acuity of the substance(s) used or medication currently taking. For instance, SEN families with SSRI-only or Nicotine-only exposure may have less need for care coordination than a family more acutely affected by prenatal substance use. The scope of work and benchmarks will be reassessed upon review of data that was collected the past two years.

How first year target was achieved (optional):

Priority #:

7

Priority Area:

Referrals from first responders to the triage center

Priority Type:

MHS, ESMI, BHCS

Population(s):

Goal of the priority area:

Increase of referrals from the first responders, including EMS, fire and police, to the triage center located in East Providence

Objective:

Divert behavioral health clients from the emergency room to more appropriate assessment and referral service.

Strategies to attain the goal:

MOUs with municipalities, outreach and engagement activities. Participation in first responders work group. Participation in daily Huddle that connects with behavioral health hospital open beds to prevent back up in emergency departments.

Edit Strategies to attain the objective here:

(if needed)

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

increase the number of clients referred to the triage center that are already identified as in crisis.

Baseline Measurement:

41 referrals from 1st responders to the triage center

First-year target/outcome measurement:

50 referrals from 1st responders to the triage center

Second-year target/outcome measurement:

60 referrals from 1st responders to the triage center

New Second-year target/outcome measurement(if needed):

Data Source:

Direct reporting from BH Link to BHDDH Project Manager.

New Data Source(if needed):

Description of Data:

Each person referred from a first responder.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

N/A

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target:

Achieved

Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

There were 28 referrals from 1st responders to the triage center which is below the target. The reasoning for this is logistical challenges including a bridge closure critical to the accessibility of BH Link that began in December 2023. There was also no liaison to bridge the relationship between 911 dispatchers and the 988-call center until August 2024.

How first year target was achieved (optional):

Priority #:

8

Priority Area:

Children Experiencing Serious Emotional Disturbance

Priority Type:

MHS, ESMI, BHCS

Population(s):

SED

Goal of the priority area:

Ensure children have access and are receiving behavioral healthcare services.

Objective:

Increase the number of children receiving contact through statewide Mobile Response and Stabilization Services (MRSS) Program

Strategies to attain the goal:

MRSS will be available to respond to outreach 24/7/365. Referrals will be accepted from the 988-crisis hotline, schools, children's hospital, primary care providers, etc.

Edit Strategies to attain the objective here:

(if needed)

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Number of children served through the statewide Mobile Response and Stabilization Services (MRSS) Program

Baseline Measurement:

543 children served through MRSS

First-year target/outcome measurement:

720 children served through MRSS

Second-year target/outcome measurement:

840 children served through MRSS

New Second-year target/outcome measurement(if needed):

Data Source:

Data is currently being collected through agency reporting to EOHHS.

New Data Source(if needed):

Description of Data:

All contracts, regardless of discretionary or block grant funding have data reporting requirements that are included in this metric.

New Description of Data:(if needed)**Data issues/caveats that affect outcome measures:**

N/A

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved,explain why)

Reason why target was not achieved, and changes proposed to meet target:

706 children were served through MRSS which is 98% of the target. The program was relatively new which makes it challenging to establish accurate baseline data and predictions for the program's performance.

How first year target was achieved (optional):

Indicator #: 2

Indicator: Number of school- based referrals to the statewide Mobile Response and Stabilization Services (MRSS) Program

Baseline Measurement: 147 school-based referrals to MRSS

First-year target/outcome measurement: 210 school-based referrals to MRSS

Second-year target/outcome measurement: 260 school-based referrals to MRSS

New Second-year target/outcome measurement(if needed):**Data Source:**

Data is currently being collected through agency reporting to EOHHS.

New Data Source(if needed):**Description of Data:**

All contracts, regardless of discretionary or block grant funding have data reporting requirements that are included in this metric.

New Description of Data:(if needed)**Data issues/caveats that affect outcome measures:**

N/A

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved,explain why)

Reason why target was not achieved, and changes proposed to meet target:

183 school-based referrals to MRSS which is 87% of the target. There were no school-based referrals to MRSS over the summer which was part of the reporting time period.

How first year target was achieved (optional):

Priority #: 9

Priority Area: Persons with Tuberculosis

Priority Type:

Population(s): TB

Goal of the priority area:

To reduce the incidence of tuberculosis in RI

Objective:

Monitor incoming and current clients for infectious disease to reduce the spread of infectious disease

Strategies to attain the goal:

- 1.) Screen incoming and clients for tuberculosis
- 2.) Referring any positive tuberculosis screen to RISE Clinic at Miriam Hospital

Edit Strategies to attain the objective here:

(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Case rate of tuberculosis in RI

Baseline Measurement: 1.3 cases per 100,000

First-year target/outcome measurement: 1.4 cases per 100,000

Second-year target/outcome measurement: 1.3 cases per 100,000

New Second-year target/outcome measurement(if needed):

Data Source:

RIDOH TB Reporting

New Data Source(if needed):

Description of Data:

Cases per 100,000 of TB as reported to RIDOH

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

There is a reporting lag between collection and dissemination. The baseline is from 2022. Also, there may be a ceiling effect due to low incidence in RI.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved,explain why)

Reason why target was not achieved, and changes proposed to meet target:

The baseline from 2022 should have been 1.6 based on updated reports. The outcome was 2.5 cases per 100,000 which is below the target. There is TB Elimination Plan which includes TB Directly Observed Therapy for every active TB case diagnosed in RI. BG isn't funding TB services.

How first year target was achieved (optional):

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

III: Expenditure Reports

Table 2 - State Agency Expenditure Report

This table provides a report of SUPTRS BG and state expenditures by the SSA during the SFY immediately preceding the FFY for which the state is applying for funds for authorized activities to prevent and treat SUDs. For detailed instructions, refer to those in the WebBGAS. Please note that this expenditure period is different from that on SUPTRS BG Table 4.

Expenditure Period Start Date: 7/1/2023 Expenditure Period End Date: 6/30/2024

Activity (See instructions for entering expenses in Row 1)	A. SUPTRS BG	B. MHBG	C. Medicaid (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 ¹	I. ARP ²
1. Substance Use Prevention (Other than Primary Prevention), Treatment, and Recovery ³	\$3,836,734.43		\$0.00	\$5,951,819.68	\$2,850,502.31	\$0.00	\$0.00	\$729,284.42	\$2,170,895.79
a. Pregnant Women and Women with Dependent Children	\$75,745.20		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
b. Recovery Support Services	\$1,738,018.71		\$0.00	\$2,662,943.79	\$1,133,508.04	\$0.00	\$0.00	\$48,589.44	\$9,322.50
c. All Other	\$2,022,970.52		\$0.00	\$3,288,875.89	\$1,716,994.27	\$0.00	\$0.00	\$680,694.98	\$2,161,573.29
2. Substance Use Disorder Primary Prevention	\$3,274,603.69		\$0.00	\$2,217,088.42	\$1,557,545.70	\$0.00	\$0.00	\$137,253.50	\$1,644,951.72
3. Tuberculosis Services	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
4. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV) ⁴	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
5. State Hospital									
6. Other 24 Hour Care									
7. Ambulatory/Community Non-24 Hour Care									
8. Mental Health Primary Prevention									
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)									
10. Administration (Excluding Program and Provider Level)	\$327,306.11		\$0.00	\$1,774,871.59	\$3,339,765.70	\$0.00	\$0.00	(\$45,269.38)	\$162,550.58
11. Total	\$7,438,644.23	\$0.00	\$0.00	\$9,943,779.69	\$7,747,813.71	\$0.00	\$0.00	\$821,268.54	\$3,978,398.09

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. If your state or territory has an approved **Second No Cost Extension (NCE)** for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until **March 14, 2025** to expend the COVID-19 Relief Supplemental Funds. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions (NoA). Per the instructions, the standard SUPTRS BG expenditures are for the state planned expenditure period of July 1, 2023 – June 30, 2025 for most states.

²The expenditure period for ARP supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025.

³Prevention other than primary prevention

⁴Only designated states as defined in 42 U.S.C. § 300x-24(b)(2) and 45 CFR § 96.128(b) for the applicable federal fiscal year should enter information in this row. This may include a state or states that were previously considered "designated states" during any of the three prior FFYs for which a state was applying for a grant. See EIS/HIV policy change in SUPTRS BG Annual Report instructions.

Please indicate the expenditures are actual or estimated.

Actual Estimated

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

Expenditures are run from the state of RI accounting program. All reports were run for the designated time frame.

H. - There is a negative in the admin for the covid funds for this period. Our fiscal department made all corrections to admin and salary and fringe at the end of the grant. Therefore the corrections generated a negative within this time frame.

III: Expenditure Reports

Table 3a – Syringe Services Program (SSP)

Expenditure Start Date: 10/01/2021 Expenditure End Date: 09/30/2023

SSP Expenditures						
SSP Agency Name	SSP Main Address	SUD Treatment Provider (Yes or No)	# Of locations (Include any mobile locations)	SUPTRS BG Funds	COVID-19 ¹ Funds	ARP ² Funds
No Data Available						

¹ The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the “standard” SUPTRS BG and MHBG. If your state or territory has an approved **Second No Cost Extension (NCE)** for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until **March 14, 2025** to expend the COVID-19 Relief Supplemental Funds. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions (NoA). Per the instructions, the standard SUPTRS BG expenditures are for the state planned expenditure period of July 1, 2023 – June 30, 2025 for most states.

² The expenditure period for The ARP supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025.

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Footnotes:

III: Expenditure Reports

Table 3b - Syringe Services Program

Expenditure Start Date: 10/1/2021 Expenditure End Date: 9/30/2023

SUPTRS							
Syringe Services Program Name	# of Unique Individuals Served		HIV Testing (Please enter total number of individuals served)	Treatment for Substance Use Conditions (Please enter total number of individuals served)	Treatment for Physical Health (Please enter total number of individuals served)	STD Testing (Please enter total number of individuals served)	Hep C (Please enter total number of individuals served)
	0	ONSITE Testing	0	0	0	0	0
		REFERRAL to testing	0	0	0	0	0
COVID-19 ¹							
Syringe Services Program Name	# of Unique Individuals Served		HIV Testing (Please enter total number of individuals served)	Treatment for Substance Use Conditions (Please enter total number of individuals served)	Treatment for Physical Health (Please enter total number of individuals served)	STD Testing (Please enter total number of individuals served)	Hep C (Please enter total number of individuals served)
	0	ONSITE Testing	0	0	0	0	0
		REFERRAL to testing	0	0	0	0	0
ARP ²							
Syringe Services Program Name	# of Unique Individuals Served		HIV Testing (Please enter total number of individuals served)	Treatment for Substance Use Conditions (Please enter total number of individuals served)	Treatment for Physical Health (Please enter total number of individuals served)	STD Testing (Please enter total number of individuals served)	Hep C (Please enter total number of individuals served)
	0	ONSITE Testing	0	0	0	0	0
		REFERRAL to testing	0	0	0	0	0

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the “standard” SUPTRS BG and MHBG. If your state or territory has an approved **Second No Cost Extension (NCE)** for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until **March 14, 2025** to expend the COVID-19 Relief Supplemental Funds. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions (NoA). Per the instructions, the standard SUPTRS BG expenditures are for the state planned expenditure period of July 1, 2023 – June 30, 2025 for most states.

² The expenditure period for ARP supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025.

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Footnotes:

III: Expenditure Reports

Table 3c – Harm Reduction Activities

Expenditure Period Start Date: 07/01/2023 Expenditure Period End Date: 06/30/2024

Harm Reduction Activities								Expenditures		
Provider/Program Name	Main Address	SSP (Yes/No)	Number of Naloxone Kits Purchased	Number of Naloxone Kits Distributed	Number of Overdose Reversals	Number of Fentanyl Test Strips Purchased	Number of Fentanyl Test Strips Distributed	SUPTRS BG Funds	COVID-19 ¹ Funds	ARP ² Funds
No Data Available										

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 – March 14, 2023, which is different from the expenditure period for the “standard” SUPTRS BG and MHBG. If your state or territory has an approved Second No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2025 to expend the COVID-19 Relief Supplemental Funds. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions (NoA). Per the instructions, the standard SUPTRS BG expenditures are for the state planned expenditure period of July 1, 2023 – June 30, 2025, for most states.

²The expenditure period for ARP supplemental funding is September 1, 2021 - September 30, 2025, which is different from the expenditure period for the “standard” MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 - June 30, 2025.

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Footnotes:

III: Expenditure Reports

Table 4 - State Agency SUPTRS BG Expenditure Compliance Report

This table is for the reporting of expenditures by category for the SUPTRS BG FY 2022 Award. States should complete this table and demonstrate compliance with SUPTRS BG statute and regulations during the two-year expenditure period for which the state was awarded. These include a minimum expenditure of no less than 20 percent for primary prevention, a capitation of 5 percent in SSA administration of the SUPTRS BG, and a required 5 percent for EIS/HIV in designated states during the award period. For detailed instructions, refer to those in WebBGAS.

Expenditure Period Start Date: 10/1/2021 Expenditure Period End Date: 9/30/2023

Expenditure Category	FY 2022 SA Block Grant Award
1. Substance Use Prevention ¹ , Treatment, and Recovery	\$3,219,516.00
2. Substance Use Primary Prevention	\$4,060,047.00
3. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV) ²	\$0.00
4. Tuberculosis Services	\$0.00
5. Administration (excluding program/provider level)	\$383,135.00
Total	\$7,662,698.00

¹Prevention other than Primary Prevention

²Only designated states as defined in 42 U.S.C. § 300x-24(b)(2) and 45 CFR § 96.128(b) for the applicable federal fiscal year should enter information in this row. This may include a state or states that were previously considered "designated states" during any of the three prior FFYs for which a state was applying for a grant. See EIS/HIV policy change in SUPTRS BG Annual Report instructions.

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Footnotes:
 Amounts based on expenditures run from the state of RI accounting system per the reporting period as indicated in the instructions.

III: Expenditure Reports

SUPTRS BG Table 5a - Primary Prevention Expenditures

This table is for the reporting of expenditures on primary prevention activities and must demonstrate the state's compliance with the statutory minimum set-aside of no less than 20 percent of the SUPTRS BG 2022 Award during the two-year award period. The state or jurisdiction must complete SUPTRS BG Table 5a. The total reported on this table should be equal to that found in Table 4, Row 2 unless the state also reports expenditures in Table 6, Column B. In which case, the sum of Table 5a + Table 6, Column B should be equal to that reported on Table 4, Row 2. Expenditures within the six strategies should be directly associated with the cost of completing the activity or task. If a state used strategies not covered by these six categories or the state is unable to calculate expenditures by strategy, please report them under "Other."

Expenditure Period Start Date: Expenditure Period End Date:

Strategy	IOM Target	Substance Use Block Grant	Other Federal	State	Local	Other
Information Dissemination	Selective					
Information Dissemination	Indicated					
Information Dissemination	Universal	\$562,844.00	\$267,176.38			
Information Dissemination	Unspecified					
Information Dissemination	Total	\$562,844.00	\$267,176.38	\$0.00	\$0.00	\$0.00
Education	Selective	\$70,355.00				
Education	Indicated					
Education	Universal	\$246,244.00	\$270,096.34			
Education	Unspecified					
Education	Total	\$316,599.00	\$270,096.34	\$0.00	\$0.00	\$0.00
Alternatives	Selective					
Alternatives	Indicated					
Alternatives	Universal	\$35,178.00	\$18,979.74			
Alternatives	Unspecified					
Alternatives	Total	\$35,178.00	\$18,979.74	\$0.00	\$0.00	\$0.00
Problem Identification and Referral	Selective	\$1,758,885.00	\$21,899.70			
Problem Identification and Referral	Indicated	\$105,533.00	\$13,139.82			
Problem Identification and Referral	Universal		\$59,859.19			
Problem Identification and Referral	Unspecified					

Problem Identification and Referral	Total	\$1,864,418.00	\$94,898.71	\$0.00	\$0.00	\$0.00
Community-Based Process	Selective					
Community-Based Process	Indicated					
Community-Based Process	Universal	\$351,777.00	\$579,612.16			
Community-Based Process	Unspecified					
Community-Based Process	Total	\$351,777.00	\$579,612.16	\$0.00	\$0.00	\$0.00
Environmental	Selective					
Environmental	Indicated					
Environmental	Universal	\$386,955.00	\$229,216.89			
Environmental	Unspecified					
Environmental	Total	\$386,955.00	\$229,216.89	\$0.00	\$0.00	\$0.00
Section 1926 (Synar)-Tobacco	Selective					
Section 1926 (Synar)-Tobacco	Indicated					
Section 1926 (Synar)-Tobacco	Universal			\$21,380.00		
Section 1926 (Synar)-Tobacco	Total	\$0.00	\$0.00	\$21,380.00	\$0.00	\$0.00
Other	Universal Direct					
Other	Universal Indirect					
Other	Selective					
Other	Indicated					
Other	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	Grand Total	\$3,517,771.00	\$1,459,980.22	\$21,380.00		

Section 1926 (Synar)-Tobacco: Costs associated with the Synar Program Pursuant to the January 19, 1996 federal regulation "Tobacco Regulation for Substance Abuse Prevention and Treatment Block Grants, Final Rule" (45 CFR § 96.130), a state may not use the SUPTRS BG to fund the enforcement of its statute, except that it may expend funds from its primary prevention set aside of its Block Grant allotment under 45 CFR §96.124(b)(1) for carrying out the administrative aspects of the requirements, such as the development of the sample design and the conducting of the inspections. States should include any non-SUPTRS BG funds* that were allotted for Synar activities in the appropriate columns under 7 below.

*Please list all sources, if possible (e.g., Centers for Disease Control and Prevention, Block Grant, foundations, etc.)

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Footnotes:

Expenditures are generated from state of RI accounting system.

Resource Development totals have been removed from the SUPTRS prevention totals.

III: Expenditure Reports

Table 5b - SUPTRS BG Primary Prevention Targeted Priorities (Required)

The purpose of the first table is for the state or jurisdiction to identify the substance and/or categories of substances it identified through its needs assessment and then addressed with primary prevention set-aside dollars from the FY 2022 SUPTRS BG NoA. The purpose of the second table is to identify each special population the state or jurisdiction selected as a priority for primary prevention set-aside expenditures.

Expenditure Period Start Date: 10/1/2021 Expenditure Period End Date: 9/30/2023

SUPTRS BG Award	
Prioritized Substances	
Alcohol	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>
Cocaine	<input type="checkbox"/>
Heroin	<input type="checkbox"/>
Inhalants	<input type="checkbox"/>
Methamphetamine	<input type="checkbox"/>
Synthetic Drugs (i.e. Bath salts, Spice, K2)	<input type="checkbox"/>
Fentanyl	<input type="checkbox"/>
Prioritized Populations	
Students in College	<input checked="" type="checkbox"/>
Military Families	<input type="checkbox"/>
LGBTQ+	<input checked="" type="checkbox"/>
American Indians/Alaska Natives	<input type="checkbox"/>
African American	<input type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>
Homeless	<input type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input type="checkbox"/>
Asian	<input type="checkbox"/>

Rural	<input type="checkbox"/>
Other Underserved Racial and Ethnic Minorities	<input type="checkbox"/>

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Footnotes:

III: Expenditure Reports

Table 6 - Non Direct Services/System Development

Expenditure Period Start Date: 10/1/2021 Expenditure Period End Date: 9/30/2023

Activity	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated ¹
1. Information Systems	\$14,229.00	\$64,079.00	\$0.00
2. Infrastructure Support	\$5,146.00	\$0.00	\$0.00
3. Partnerships, community outreach, and needs assessment	\$79,432.00	\$51,688.00	\$0.00
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	\$0.00	\$0.00	\$0.00
5. Quality Assurance and Improvement	\$0.00	\$0.00	\$0.00
6. Research and Evaluation	\$15,236.00	\$154,628.00	\$0.00
7. Training and Education	\$376,476.00	\$271,882.00	\$0.00
8. Total	\$490,519.00	\$542,277.00	\$0.00

¹Integrated refers to funds both treatment and prevention portions of the SUPTRS BG for overarching activities.

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Footnotes:

Expenditures based on data taken from the state's accounting system and coded by appropriate modality.

Expenditures on this form do not appear on Form 5a or 7.

III: Expenditure Reports

Table 7 - Statewide Entity Inventory

This table provides a report of the sub-recipients of SUPTRS BG funds including community and faith-based organizations which provided SUD prevention activities and treatment services, as well as intermediaries/administrative service organizations. Table 7 excludes system development/non-direct service expenditures.

Expenditure Period Start Date: 10/01/2021 Expenditure Period End Date: 09/30/2023

Source of Funds Substance Use Block Grant																
Entity Number	I-BHS ID (formerly I-SATS)		Area Served (Statewide or SubState Planning Area)	Provider / Program Name	Street Address	City	State	Zip	A. All SUPTRS BG Funds	B. Prevention (other than primary prevention) and Treatment Services	C. Pregnant Women and Women with Dependent Children	D. Primary Prevention	E. Early Intervention Services for HIV	F. Syringe Services Program	G. Opioid Treatment Programs (OTPs)	H. Office-based opioid treatment (OBOTs)
N/A	N/A		Statewide	2nd Act	188 Valley Street Suite 206	Providence	RI	02909	\$6,247.00	\$6,247.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
MABSAS-2149	RI750156		Statewide	Bridgemark Inc	1990 Elmwood Avenue	Warwick	RI	02888	\$127,434.00	\$127,434.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
RI100279	RI100279		Statewide	Coastland EAP	120 Centerville Road Center Point Office Park	Warwick	RI	02886	\$2,069,554.00	\$0.00	\$0.00	\$2,069,554.00	\$0.00	\$0.00	\$0.00	\$0.00
RI100043	RI100043		Statewide	Community Care Alliance	P.O. Box 1700	Woonsocket	RI	02895	\$1,874.00	\$1,874.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
RI100589	RI100589		Statewide	East Bay Center Inc	2 Old County Road	Barrington	RI	02806	\$104,321.00	\$104,321.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
GMF1	RI100568		Statewide	Galilee Mission Inc	P.O. Box 459	Narragansett	RI	02882	\$4,373.00	\$4,373.00	\$4,373.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
TRI3	RI100220		Statewide	Gateway Healthcare - Womens Residential	Gateway Healthcare 1443 Hartford Avenue	Johnston	RI	02919	\$7,496.00	\$7,496.00	\$7,496.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
N/A	N/A		Statewide	Horizon Health Partners	975 Waterman Ave	East Providence	RI	02914	\$1,007,604.00	\$1,007,604.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
PSN1	N/A		Statewide	Parent Support Network	535 Centerville Road	Warwick	RI	02896	\$256,742.00	\$256,742.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
N/A	N/A		Statewide	RISAPA Community TASK Forces	14 Harrington Road	Cranston	RI	02920	\$1,451,124.00	\$0.00	\$0.00	\$1,451,124.00	\$0.00	\$0.00	\$0.00	\$0.00
N/A	N/A		Statewide	Serenity Center	66 Social Street	Woonsocket	RI	02895	\$100,573.00	\$100,573.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
N/A	N/A		Statewide	Standard Modern	186 Duchaine Boulevard	New Bedford	MA	02745	\$11,243.00	\$11,243.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
TPC4	RI900991		Statewide	The Providence Center - Long Term Care	530 North Main Street	Providence	RI	02904	\$389,798.00	\$389,798.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
RI100584	RI100584		Statewide	The Providence Center - Peers	1070 Main Street	Pawtucket	RI	02860	\$270,485.00	\$270,485.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
RI100865	RI100865		Statewide	The Providence Center - Plain Street	1002 Broad Street	Central Falls	RI	02863	\$81,208.00	\$81,208.00	\$81,208.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
TPCRCCProv	N/A		Statewide	The Providence Center - Providence RCC	300 Reservoir Ave	Providence	RI	02907	\$172,411.00	\$172,411.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
TPCRCCWar	N/A		Statewide	The Providence Center - Warwick RCC	890 Centerville Road	Providence	RI	02886	\$184,280.00	\$184,280.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Total										\$6,246,767.00	\$2,726,089.00	\$93,077.00	\$3,520,678.00	\$0.00	\$0.00	\$0.00	\$0.00
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* Indicates the imported record has an error.

Note: ¹42 CFR 8.12: Federal Opioid Treatment Standards (OTP) providers only
 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:
 Expenditures come directly from the state of RI's accounting system during the designated time frame.

III: Expenditure Reports

Table 8a - Maintenance of Effort for State Expenditures for SUD Prevention, Treatment, and Recovery

This Maintenance of Effort table provides a description of non-federal state expenditures for authorized activities to prevent and treat substance use and provide recovery services flowing through the Single State Agency (SSA) during the state fiscal year immediately preceding the federal fiscal year for which the state is applying for funds.

Expenditure Period Start Date: 07/01/2023 Expenditure Period End Date: 06/30/2024

Total Single State Agency (SSA) Expenditures for Substance Abuse Prevention and Treatment		
Period (A)	Expenditures (B)	<u>B1(2022) + B2(2023)</u> 2 (C)
SFY 2022 (1)	\$9,968,911.69	
SFY 2023 (2)	\$11,237,818.47	\$10,603,365.08
SFY 2024 (3)	\$11,237,818.47	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

SFY 2022	Yes	X	No
SFY 2023	Yes	X	No
SFY 2024	Yes		No X

Did the state or jurisdiction have any non-recurring expenditures as described in 42 U.S.C. § 300x-30(b) for a specific purpose which were not included in the MOE calculation?

Yes No X

If yes, specify the amount and the State fiscal year:

If yes, SFY:

Did the state or jurisdiction include these funds in previous year MOE calculations?

Yes No

When did the State or Jurisdiction submit an official request to SAMHSA to exclude these funds from the MOE calculations?

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: 3/15/2025

Please provide a description of the amounts and methods used to calculate the total Single State Agency (SSA) expenditures for substance use disorder prevention and treatment 42 U.S.C. §300x-30.

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:
Based on previous numbers and years, we are asking for an extension to run final numbers. we are asking for an extension of 3/17/2025.

III: Expenditure Reports

Table 8b - Expenditures for Services to Pregnant Women and Women with Dependent Children

This MOE table provides a report of state and SUBG funds expended on specialized SUD treatment services for pregnant women and women with dependent children for the state fiscal year immediately preceding the FFY for which the state is applying for funds.

Expenditure Period Start Date: 07/01/2023 Expenditure Period End Date: 06/30/2024

Base

Period	Total Women's Base (A)
SFY 1994	\$ 1,964,739.00

Maintenance

Period	Total Women's Base (A)	Total Expenditures (B)	Expense Type
SFY 2022		\$ 3,108,857.79	
SFY 2023		\$ 4,188,119.70	
SFY 2024		\$ 3,648,488.75	<input type="radio"/> Actual <input checked="" type="radio"/> Estimated

Enter the amount the State plans to expend in SFY 2025 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Section III: Table 8b – Expenditures for Services to Pregnant Women and Women with Dependent Children, Base, Total Women’s Base (A) for Period of (SFY 1994)): \$ 3,648,488.75;

Please provide a description of the amounts and methods used to calculate the base and, for 1994 and subsequent fiscal years, report the Federal and State expenditures for such services for services to pregnant women and women with dependent children as required by 42 U.S.C. §300x-22(b)(1). This amount is a combination of expenditures for the division via contracts (federal and state dollars), as well as Medicaid claims for programs that meet the criteria for women's services. Currently this is an estimate based on the last two years. (FY2022 and FY2023) . We will update once our data unit is able to provide actual expenditures.

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

IV: Population and Services Reports

Table 9 - Prevention Strategy Report

This table requires additional information (pursuant to Section 1929 of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-29) about the primary prevention activities conducted by the entities listed on SUPTRS BG Table 7.

Expenditure Period Start Date: 10/1/2021 Expenditure Period End Date: 9/30/2023

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Already using substances	1. Information Dissemination	
	1. Clearinghouse/information resources centers	
	2. Resources directories	
	3. Media campaigns	
	4. Brochures	
	5. Radio and TV public service announcements	
	6. Speaking engagements	
	7. Health fairs and other health promotion, e.g., conferences, meetings, seminars	
	2. Education	
	2. Ongoing classroom and/or small group sessions	
	3. Peer leader/helper programs	
	4. Education programs for youth groups	
	3. Alternatives	
	1. Drug free dances and parties	
	4. Community service activities	
	6. Recreation activities	
	4. Problem Identification and Referral	
	2. Student Assistance Programs	
	5. Community-Based Process	
	1. Community and volunteer training, e.g., neighborhood action training, impactor-training, staff/officials training	
	2. Systematic planning	
	3. Multi-agency coordination and collaboration/coalition	
	4. Community team-building	
	5. Accessing services and funding	
	6. Environmental	
	1. Promoting the establishment	

	or review of alcohol, tobacco, and drug use policies in schools	
	2. Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drugs	
	3. Modifying alcohol and tobacco advertising practices	

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Footnotes:

IV: Population and Services Reports

Table 10a – Treatment Utilization Matrix

This table is intended to capture the count of persons with initial admissions and subsequent admission(s) to an episode of care.

Expenditure Period Start Date: 7/1/2023

Expenditure Period End Date: 6/30/2024

Level of Care	SUPTRS BG Number of Admissions > Number of Persons Served		COVID-19 Number of Admissions > Number of Persons Served ¹		ARP Number of Admissions > Number of Persons Served ²		SUPTRS BG Service Costs			COVID-19 Costs ¹			ARP Costs ²		
	Number of Admissions (A)	Number of Persons Served (B)	Number of Admissions (C)	Number of Persons Served (D)	Number of Admissions (E)	Number of Persons Served (F)	Mean (G)	Median (H)	Standard Deviation (I)	Mean Cost (J)	Median Cost (K)	Standard Deviation (L)	Mean Cost (M)	Median Cost (N)	Standard Deviation (O)
DETOXIFICATION (24-HOUR CARE)															
1. Hospital Inpatient	0	0													
2. Free-Standing Residential	1,224	357													
REHABILITATION/RESIDENTIAL															
3. Hospital Inpatient															
4. Short-term (up to 30 days)	72	36													
5. Long-term (over 30 days)	2,142	1,041													
AMBULATORY (OUTPATIENT)															
6. Outpatient	1,349	1,078													
7. Intensive Outpatient	993	455													
8. Detoxification	4	4													
OUD MEDICATION ASSISTED TREATMENT															
9. MOUD Medication-Assisted Detoxification	14	9													
10. MOUD Medication-Assisted Treatment Outpatient	1,787	1,305													

Please explain why Column A (SUPTRS BG and COVID-19 Number of Admissions) are less than Column B (SUPTRS BG and COVID-19 Number of Persons Served)

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 – March 14, 2023, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. If your state or territory has an approved Second No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2025 to expend the COVID-19 Relief Supplemental Funds. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions (NoA). Per the instructions, the standard SUPTRS BG expenditures are for the state planned expenditure period of July 1, 2023 – June 30, 2025 for most states.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025.

³In FY 2020 SAMHSA modified the "Level of Care" (LOC) and "Type of Treatment Service/Setting" to "Medication-Assisted Treatment" and "Medication-Assisted Treatment," respectively. In prior SUPTRS BG Reports, the LOC was entitled "Opioid Replacement Therapy" and the Type of Treatment Service/Setting included "Opioid Replacement Therapy," Row 9 and "ORT Outpatient," Row 10. The changes inadvertently created a barrier for data analysis as one-to-one mapping of the data submitted in the FY 2020 Table 10 to the data submitted in prior Reports is not possible. In the current and future SUPTRS BG Reports, the LOC is "MOUD & Medication Assisted Treatment" and the Types of Treatment Service/Setting will include "MOUD Medication-Assisted Treatment Detoxification," Row 9 and "MOUD & Medication Assisted Treatment Outpatient," Row 10. MOUD & Medication-Assisted Treatment Withdrawal Management includes hospital detoxification, residential detoxification, or ambulatory detoxification services/settings AND Opioid Medication-Assisted Treatment. MOUD & Medication Assisted Treatment Outpatient includes outpatient services/settings AND Opioid Medication-Assisted Treatment.

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

IV: Population and Services Reports

Table 10b – Number of Persons Served (Unduplicated Count) Who Received Recovery Supports

This table provides an aggregate profile of the unduplicated persons that received recovery support services funded through the SUPTRS BG by age and gender identity. For detailed instructions, see those in WebBGAS.

Expenditure Period Start Date: 07/01/2023 Expenditure Period End Date: 06/30/2024

	Age 0-5 ¹							Age 6-12						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Support Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Housing	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0

¹Age category 0-5 years is not applicable.

	Age 13-17							Age 18-20						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	0	0	0	0	0	0	0	87	149	0	0	0	0	0
Peer-Led Support Group	0	0	0	0	0	0	0	0	6	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Housing	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	Age 21-24							Age 25-44						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	271	406	0	0	0	0	0	4,092	7,641	0	1	19	6	2
Peer-Led Support Group	12	30	0	0	0	0	0	883	462	0	1	3	0	2
Peer-Led Training or Peer Certification Activity	0	1	0	0	0	0	0	8	5	0	0	0	0	0
Recovery Housing	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	1	3	0	0	0	0	0	49	33	0	1	1	0	2
Other SAMHSA Approved Recovery Support Event or Activity	1	3	0	0	0	0	0	49	33	0	1	1	0	2

	Age 45-64							Age 65-74						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
Peer-to-Peer Support Individual	4,417	8,744	1	0	4	244	1	734	1,222	0	0	0	0	0
Peer-Led Support Group	642	1,051	1	0	0	0	1	165	241	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	4	6	0	0	0	0	0	1	2	0	0	0	0	0
Recovery Housing	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	38	56	1	0	0	0	1	6	8	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	38	56	1	0	0	0	1	6	8	0	0	0	0	0

	Age 75+							Age Not Available						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
Peer-to-Peer Support Individual	68	86	0	0	0	0	0	1,379	1,555	0	0	1	11	0
Peer-Led Support Group	4	6	0	0	0	0	0	693	840	0	0	0	122	0
Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0	0	0	0	0	0	0	3	0
Recovery Housing	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	0	0	0	0	0	0	0	7	18	0	0	0	104	0
Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	4	2	0	0	0	0	0	0	1	0	0	0	49	0
Other SAMHSA Approved Recovery Support Event or Activity	4	2	0	0	0	0	0	0	1	0	0	0	313	0

	Total							
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	
Peer-to-Peer Support Individual	11,048	19,803	1	1	24	261	3	
Peer-Led Support Group	2,399	2,636	1	1	3	122	3	
Peer-Led Training or Peer Certification Activity	13	14	0	0	0	3	0	
Recovery Housing	0	0	0	0	0	0	0	
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	
Recovery Support Service Transportation	7	18	0	0	0	104	0	
Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	0	

Recovery Social Support or Social Inclusion Activity	98	103	1	1	1	49	3
Other SAMHSA Approved Recovery Support Event or Activity	98	103	1	1	1	313	3
Comments on Data (Age):							
Comments on Data (Gender):							
Comments on Data (Overall):	Agencies are working on improving their demographic data collection,						

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

IV: Population and Services Reports

Tables 11a, 11b and 11c - Unduplicated Count of Persons Served for Alcohol and Other Drug Use

This table provides an aggregate profile of the unduplicated number of admissions and persons for services funded through the SUPTRS BG. This table should not include persons served using COVID-19 Relief Supplemental Funding.

Expenditure Period Start Date: 07/01/2023 Expenditure Period End Date: 06/30/2024

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use

This table provides an aggregate profile of the unduplicated number of admissions and persons for services funded through SUPTRS BG. This table should not include persons served using COVID-19 Relief Supplemental Funding.

	Total							American Indian or Alaska Native							
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Total	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	4	6	0	0	0	0	0	10	0	0	0	0	0	0	0
13-17 years	6	1	0	0	0	0	0	7	0	0	0	0	0	0	0
18-20 years	17	21	0	0	2	0	0	40	0	1	0	0	0	0	0
21-24 years	64	98	0	0	6	0	0	168	0	5	0	0	0	0	0
25-44 years	844	1,757	0	0	36	0	0	2,637	9	23	0	0	0	0	0
45-64 years	357	977	0	0	10	0	0	1,344	3	24	0	0	0	0	0
65-74 years	21	38	0	0	3	0	0	62	0	0	0	0	0	0	0
75+ years	2	5	0	0	0	0	0	7	0	1	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	1,315	2,903	0	0	57	0	0	4,275	12	54	0	0	0	0	0
Pregnant Women	22								0						
Number of Persons Served who were admitted in a Period Prior to the 12-month reporting Period	7134														
Number of Persons Served outside of the levels of care described on SUPTRS BG Table 10	0														

Are the values reported in this table generated from a client-based system with unique identifiers?

Yes No

Comments on Data (Race)	
Comments on Data (Gender)	We are slated to go live with a new data collection system on 12/1/24 where we will align the data collection with these gender identity options. For now, I placed individuals who answered 'No' to 'Does your gender identity align with the sex you were assigned at birth' into the Gender Non-Conforming bin as this is the structure of our current gender identity question.
Comments on Data (Overall)	We do not currently have pansexual, queer, or questioning as sexual orientation options but hope to add them.

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use (continued)

	Asian							Black or African American						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0

6-12 years	0	0	0	0	0	0	0	1	2	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	1	0	0	0	0	0	0
18-20 years	1	0	0	0	0	0	0	1	4	0	0	0	0	0
21-24 years	8	13	0	0	0	0	0	2	13	0	0	1	0	0
25-44 years	0	0	0	0	0	0	0	62	206	0	0	4	0	0
45-64 years	1	3	0	0	0	0	0	31	95	0	0	3	0	0
65-74 years	0	0	0	0	0	0	0	3	8	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	10	16	0	0	0	0	0	101	328	0	0	8	0	0
Pregnant Women	0							2						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use (continued)

	Native Hawaiian or Other Pacific Islander							White						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	3	3	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	4	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	14	9	0	0	1	0	0
21-24 years	0	0	0	0	0	0	0	37	39	0	0	4	0	0
25-44 years	4	8	0	0	0	0	0	660	1,150	0	0	21	0	0
45-64 years	0	1	0	0	0	0	0	284	709	0	0	5	0	0
65-74 years	0	0	0	0	0	0	0	16	28	0	0	3	0	0
75+ years	0	0	0	0	0	0	0	2	2	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	4	9	0	0	0	0	0	1,020	1,940	0	0	34	0	0
Pregnant Women	0							15						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use (continued)

	Some Other Race							More than One Race Reported						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	1	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	1	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	1	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	6	2	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	24	53	0	0	4	0	0
45-64 years	0	0	0	0	0	0	0	9	15	0	0	1	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0

75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	39	73	0	0	5	0	0
Pregnant Women	0							1						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use (continued)

	Race Not Available							Not Hispanic or Latino						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	4	6	0	0	0	0	0
13-17 years	1	0	0	0	0	0	0	4	0	0	0	0	0	0
18-20 years	1	6	0	0	1	0	0	15	17	0	0	0	0	0
21-24 years	11	26	0	0	1	0	0	44	59	0	0	0	0	0
25-44 years	85	317	0	0	7	0	0	778	1,455	0	0	0	0	0
45-64 years	29	130	0	0	1	0	0	334	860	0	0	0	0	0
65-74 years	2	2	0	0	0	0	0	21	37	0	0	0	0	0
75+ years	0	2	0	0	0	0	0	2	3	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	129	483	0	0	10	0	0	1,202	2,437	0	0	0	0	0
Pregnant Women	4							19						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use (continued)

	Hispanic or Latino							Hispanic or Latino Origin Not Available						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	2	1	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	3	5	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	15	29	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	97	336	0	0	0	0	0	0	0	0	0	0	0	0
45-64 years	27	123	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	2	2	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	2	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	146	498	0	0	0	0	0	0	0	0	0	0	0	0
Pregnant Women	3							0						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use¹

This table provides an aggregate profile of the unduplicated number of admissions and persons for services funded under COVID-19 Relief Supplemental Funding.

Total	American Indian or Alaska Native
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	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Total	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years ²	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pregnant Women	0								0						

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 – March 14, 2023, which is different from the expenditure period for the “standard” SUPTRS BG and MHBG. If your state or territory has an approved Second No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2025 to expend the COVID-19 Relief Supplemental Funds. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions (NoA). Per the instructions, the standard SUPTRS BG expenditures are for the state planned expenditure period of July 1, 2023 – June 30, 2025 for most states.

²Age category 0-5 years is not applicable.

Comments on Data (Race)	
Comments on Data (Gender)	
Comments on Data (Overall)	

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use (continued)

	Asian							Black or African American						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pregnant Women	0							0						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use (continued)

	Native Hawaiian or Other Pacific Islander							White						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pregnant Women	0							0						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use (continued)

	Some Other Race							More than One Race Reported						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pregnant Women	0							0						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use (continued)

	Race Not Available							Not Hispanic or Latino						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0

18-20 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	2	0	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	2	0	0	0	0	0	0
Pregnant Women	0							0						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use (continued)

	Hispanic or Latino							Hispanic or Latino Origin Not Available						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pregnant Women	0							0						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11c - Sexual Orientation Unduplicated Count of Persons Served for Alcohol and Other Drugs

A. Age	Sexual Orientation									
	B. Straight or Heterosexual	C. Homosexual (Gay or Lesbian)	D. Bisexual	E. Queer	F. Pansexual	G. Questioning	H. Asexual	I. Other	J. Not Available	
0-5 years ¹	0	0	0	0	0	0	0	0	0	
6-12 years	5	0	0	0	0	0	0	0	5	
13-17 years	6	0	1	0	0	0	0	0	0	
18-20 years	28	0	1	0	0	0	0	0	11	
21-24 years	108	3	7	0	0	0	0	3	26	
25-44 years	2,032	45	67	0	0	0	0	6	518	
45-64 years	964	14	17	0	0	0	0	3	346	
65-74 years	52	1	1	0	0	0	0	1	7	
75+ years	7	0	0	0	0	0	0	0	0	

TOTAL	3,202	63	94	0	0	0	0	13	913
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¹Age category 0-5 years is not applicable.

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

IV: Population and Services Reports

Table 12 - SUPTRS BG Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV) in Designated States

Expenditure Period Start Date: 7/1/2023

Expenditure Period End Date: 6/30/2024

Early Intervention Services for Human Immunodeficiency Virus (HIV)		
1. Number of EIS/HIV projects among SUPTRS BG sub-recipients in the state	Statewide:	Rural:
2. Total number of individuals tested through SUPTRS BG sub-recipient EIS/HIV projects:		
3. Total number of HIV tests conducted with SUPTRS BG EIS/HIV funds:		
4. Total number of tests that were positive for HIV		
5. Total number of individuals who prior to the 12-month reporting period were unaware of their HIV infection		
6. Total number of HIV-infected individuals who were diagnosed and referred into treatment and care during the 12-month reporting period		
7. Total number of persons at risk for HIV/AIDS referred for PrEP services?		
Identify barriers, including State laws and regulations, that exist in carrying out HIV testing services:		

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

Rhode Island was not a designated state in FY24.

IV: Population and Services Reports

Table 13 - Charitable Choice – Required

Under Charitable Choice Provisions; Final Rule (42 CFR Part 54), states, local governments, and religious organizations, such as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide to all potential and actual program beneficiaries (services recipients) notice of their right to alternative services; (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the state to be accessible and comparable and provided within a reasonable period of time from another substance use disorder provider ("alternative provider") to which the program beneficiary (services recipient) has no religious objection. The purpose of this table is to document how the state is complying with these provisions.

Expenditure Period Start Date: 7/1/2023 Expenditure Period End Date: 6/30/2024

Notice to Program Beneficiaries - Check all that apply:

- Used model notice provided in final regulation.
- Used notice developed by State (please attach a copy to the Report).
- State has disseminated notice to religious organizations that are providers.
- State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- State has developed specific referral system for this requirement.
- State has incorporated this requirement into existing referral system(s).
- SAMHSA's Behavioral Health Treatment Locator is used to help identify providers.
- Other networks and information systems are used to help identify providers.
- State maintains record of referrals made by religious organizations that are providers.

0 Enter the total number of referrals to other substance use disorder providers ("alternative providers") necessitated by religious objection, as defined above, made during the state fiscal year immediately preceding the federal fiscal year for which the state is applying for funds. Provide the total only. No information on specific referrals is required. If no alternative referrals were made, enter zero.

Provide a brief description (one paragraph) of any training for local governments and/or faith-based and/or community organizations that are providers on these requirements.

No training was provided.

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

V: Performance Data and Outcomes

Table 14 - Treatment Performance Measure: Employment/Education Status (From Admission to Discharge)

Short-term Residential(SR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	626	706
Total number of clients with non-missing values on employment/student status [denominator]	1,864	1,864
Percent of clients employed or student (full-time and part-time)	33.6%	37.9%
Notes (for this level of care):		
Number of CY 2023 admissions submitted:		1,495
Number of CY 2023 discharges submitted:		1,974
Number of CY 2023 discharges linked to an admission:		1,963
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):		1,864

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 11/15/2024]

Long-term Residential(LR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	2	10
Total number of clients with non-missing values on employment/student status [denominator]	202	202
Percent of clients employed or student (full-time and part-time)	1.0%	5.0%
Notes (for this level of care):		
Number of CY 2023 admissions submitted:		194
Number of CY 2023 discharges submitted:		205
Number of CY 2023 discharges linked to an admission:		205
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		0

Number of CY 2023 linked discharges eligible for this calculation (non-missing values):	202
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Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
 [Records received through 11/15/2024]

Outpatient (OP)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	1,239	1,365
Total number of clients with non-missing values on employment/student status [denominator]	1,973	1,973
Percent of clients employed or student (full-time and part-time)	62.8%	69.2%
Notes (for this level of care):		
Number of CY 2023 admissions submitted:		5,374
Number of CY 2023 discharges submitted:		5,184
Number of CY 2023 discharges linked to an admission:		4,479
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):		1,973

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
 [Records received through 11/15/2024]

Intensive Outpatient (IO)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	251	281
Total number of clients with non-missing values on employment/student status [denominator]	553	553
Percent of clients employed or student (full-time and part-time)	45.4%	50.8%
Notes (for this level of care):		
Number of CY 2023 admissions submitted:		810
Number of CY 2023 discharges submitted:		696
Number of CY 2023 discharges linked to an admission:		602
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		0

Number of CY 2023 linked discharges eligible for this calculation (non-missing values):

553

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 11/15/2024]

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

V: Performance Data and Outcomes

Table 15 - Treatment Performance Measure: Stability of Housing (From Admission to Discharge)

Short-term Residential(SR)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	1,554	1,553
Total number of clients with non-missing values on living arrangements [denominator]	1,929	1,929
Percent of clients in stable living situation	80.6%	80.5%
Notes (for this level of care):		
Number of CY 2023 admissions submitted:		1,495
Number of CY 2023 discharges submitted:		1,974
Number of CY 2023 discharges linked to an admission:		1,963
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):		1,929

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 11/15/2024]

Long-term Residential(LR)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	195	195
Total number of clients with non-missing values on living arrangements [denominator]	203	203
Percent of clients in stable living situation	96.1%	96.1%
Notes (for this level of care):		
Number of CY 2023 admissions submitted:		194
Number of CY 2023 discharges submitted:		205
Number of CY 2023 discharges linked to an admission:		205
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):		203

Outpatient (OP)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	2,058	2,058
Total number of clients with non-missing values on living arrangements [denominator]	2,134	2,134
Percent of clients in stable living situation	96.4%	96.4%
Notes (for this level of care):		
Number of CY 2023 admissions submitted:		5,374
Number of CY 2023 discharges submitted:		5,184
Number of CY 2023 discharges linked to an admission:		4,479
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):		2,134

Intensive Outpatient (IO)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	539	539
Total number of clients with non-missing values on living arrangements [denominator]	586	586
Percent of clients in stable living situation	92.0%	92.0%
Notes (for this level of care):		
Number of CY 2023 admissions submitted:		810
Number of CY 2023 discharges submitted:		696
Number of CY 2023 discharges linked to an admission:		602
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):		586

Footnotes:

V: Performance Data and Outcomes

Table 16 - Treatment Performance Measure: Criminal Justice Involvement (From Admission to Discharge)

Short-term Residential(SR)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	1,519	1,590
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	1,618	1,618
Percent of clients without arrests	93.9%	98.3%
Notes (for this level of care):		
Number of CY 2023 admissions submitted:		1,495
Number of CY 2023 discharges submitted:		1,974
Number of CY 2023 discharges linked to an admission:		1,963
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):		1,618

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 11/15/2024]

Long-term Residential(LR)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	180	194
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	204	204
Percent of clients without arrests	88.2%	95.1%
Notes (for this level of care):		
Number of CY 2023 admissions submitted:		194
Number of CY 2023 discharges submitted:		205
Number of CY 2023 discharges linked to an admission:		205
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		0

Number of CY 2023 linked discharges eligible for this calculation (non-missing values):	204
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Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
 [Records received through 11/15/2024]

Outpatient (OP)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	1,586	1,624
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	1,676	1,676
Percent of clients without arrests	94.6%	96.9%
Notes (for this level of care):		
Number of CY 2023 admissions submitted:		5,374
Number of CY 2023 discharges submitted:		5,184
Number of CY 2023 discharges linked to an admission:		4,479
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):		1,676

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
 [Records received through 11/15/2024]

Intensive Outpatient (IO)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	359	366
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	375	375
Percent of clients without arrests	95.7%	97.6%
Notes (for this level of care):		
Number of CY 2023 admissions submitted:		810
Number of CY 2023 discharges submitted:		696
Number of CY 2023 discharges linked to an admission:		602
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		0

Number of CY 2023 linked discharges eligible for this calculation (non-missing values):

375

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 11/15/2024]

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

V: Performance Data and Outcomes

Table 17 - Treatment Performance Measure: Change in Abstinence - Alcohol Use (From Admission to Discharge)

Short-term Residential(SR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	716	1,198
All clients with non-missing values on at least one substance/frequency of use [denominator]	1,960	1,960
Percent of clients abstinent from alcohol	36.5%	61.1%

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		530
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,244	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		42.6%

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		668
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	716	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		93.3%

Notes (for this level of care):

Number of CY 2023 admissions submitted:	1,495
Number of CY 2023 discharges submitted:	1,974
Number of CY 2023 discharges linked to an admission:	1,963
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):	1,960

Long-term Residential(LR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	141	169
All clients with non-missing values on at least one substance/frequency of use [denominator]	205	205
Percent of clients abstinent from alcohol	68.8%	82.4%

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		39
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	64	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		60.9%

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		130
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	141	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		92.2%

Notes (for this level of care):

Number of CY 2023 admissions submitted:	194
Number of CY 2023 discharges submitted:	205
Number of CY 2023 discharges linked to an admission:	205
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):	205

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	1,301	1,594
All clients with non-missing values on at least one substance/frequency of use [denominator]	2,203	2,203
Percent of clients abstinent from alcohol	59.1%	72.4%

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		445
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	902	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		49.3%

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		1,149
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,301	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		88.3%

Notes (for this level of care):

Number of CY 2023 admissions submitted:	5,374
Number of CY 2023 discharges submitted:	5,184
Number of CY 2023 discharges linked to an admission:	4,479
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):	2,203

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 11/15/2024]

Intensive Outpatient (IO)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	319	417
All clients with non-missing values on at least one substance/frequency of use [denominator]	599	599
Percent of clients abstinent from alcohol	53.3%	69.6%

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		142
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	280	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		50.7%

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		275
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	319	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		86.2%

Notes (for this level of care):

Number of CY 2023 admissions submitted:	810
Number of CY 2023 discharges submitted:	696
Number of CY 2023 discharges linked to an admission:	602
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):	599

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file [Records received through 11/15/2024]

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

V: Performance Data and Outcomes

Table 18 - Treatment Performance Measure: Change in Abstinence - Other Drug Use (From Admission to Discharge)

Short-term Residential(SR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	942	1,126
All clients with non-missing values on at least one substance/frequency of use [denominator]	1,960	1,960
Percent of clients abstinent from drugs	48.1%	57.4%

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		290
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,018	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		28.5%

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		836
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	942	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		88.7%

Notes (for this level of care):

Number of CY 2023 admissions submitted:	1,495
Number of CY 2023 discharges submitted:	1,974
Number of CY 2023 discharges linked to an admission:	1,963
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):	1,960

Long-term Residential(LR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	92	97
All clients with non-missing values on at least one substance/frequency of use [denominator]	205	205
Percent of clients abstinent from drugs	44.9%	47.3%

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		43
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	113	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		38.1%

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		54
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	92	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		58.7%

Notes (for this level of care):

Number of CY 2023 admissions submitted:	194
Number of CY 2023 discharges submitted:	205
Number of CY 2023 discharges linked to an admission:	205
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):	205

Outpatient (OP)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	1,450	1,340
All clients with non-missing values on at least one substance/frequency of use [denominator]	2,203	2,203
Percent of clients abstinent from drugs	65.8%	60.8%

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		184
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	753	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		24.4%

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		1,156
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,450	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		79.7%

Notes (for this level of care):

Number of CY 2023 admissions submitted:	5,374
Number of CY 2023 discharges submitted:	5,184
Number of CY 2023 discharges linked to an admission:	4,479
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):	2,203

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file [Records received through 11/15/2024]

Intensive Outpatient (IO)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	368	338
All clients with non-missing values on at least one substance/frequency of use [denominator]	599	599
Percent of clients abstinent from drugs	61.4%	56.4%

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		48
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	231	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		20.8%

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		290
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	368	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		78.8%

Notes (for this level of care):

Number of CY 2023 admissions submitted:	810
Number of CY 2023 discharges submitted:	696
Number of CY 2023 discharges linked to an admission:	602
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):	599

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
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0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

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V: Performance Data and Outcomes

Table 19 – State Description of Social Support of Recovery Data Collection

Short-term Residential(SR)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	265	1,637
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	1,794	1,794
Percent of clients participating in self-help groups	14.8%	91.2%
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	76.5%	
Notes (for this level of care):		
Number of CY 2023 admissions submitted:		1,495
Number of CY 2023 discharges submitted:		1,974
Number of CY 2023 discharges linked to an admission:		1,963
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):		1,794

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 11/15/2024]

Long-term Residential(LR)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	7	17
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	180	180
Percent of clients participating in self-help groups	3.9%	9.4%
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	5.6%	
Notes (for this level of care):		
Number of CY 2023 admissions submitted:		194
Number of CY 2023 discharges submitted:		205

Number of CY 2023 discharges linked to an admission:	205
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):	180

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 11/15/2024]

Outpatient (OP)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	167	160
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	2,003	2,003
Percent of clients participating in self-help groups	8.3%	8.0%
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	-0.3%	

Notes (for this level of care):

Number of CY 2023 admissions submitted:	5,374
Number of CY 2023 discharges submitted:	5,184
Number of CY 2023 discharges linked to an admission:	4,479
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):	2,003

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 11/15/2024]

Intensive Outpatient (IO)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	87	90
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	515	515
Percent of clients participating in self-help groups	16.9%	17.5%
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	0.6%	

Notes (for this level of care):

Number of CY 2023 admissions submitted:	810
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Number of CY 2023 discharges submitted:	696
Number of CY 2023 discharges linked to an admission:	602
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2023 linked discharges eligible for this calculation (non-missing values):	515

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
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Table 20 - Retention - Length of Stay (in Days) of Clients Completing Treatment

Level of Care	Average (Mean)	25 th Percentile	50 th Percentile (Median)	75 th Percentile
DETOXIFICATION (24-HOUR CARE)				
1. Hospital Inpatient	0	0	0	0
2. Free-Standing Residential	7	4	6	6
REHABILITATION/RESIDENTIAL				
3. Hospital Inpatient	5	4	5	5
4. Short-term (up to 30 days)	29	11	19	29
5. Long-term (over 30 days)	52	16	39	69
AMBULATORY (OUTPATIENT)				
6. Outpatient	131	34	77	148
7. Intensive Outpatient	53	21	36	57
8. Detoxification	2	2	2	2
OUD MEDICATION ASSISTED TREATMENT				
9. OUD Medication-Assisted Detoxification ¹	217	11	190	380
10. OUD Medication-Assisted Treatment Outpatient ²	175	29	86	236

Level of Care	2023 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
DETOXIFICATION (24-HOUR CARE)		
1. Hospital Inpatient	0	0
2. Free-Standing Residential	1510	1504
REHABILITATION/RESIDENTIAL		
3. Hospital Inpatient	2	2
4. Short-term (up to 30 days)	1974	1963

5. Long-term (over 30 days)	205	205
AMBULATORY (OUTPATIENT)		
6. Outpatient	5184	2219
7. Intensive Outpatient	696	602
8. Detoxification	12	1
OUD MEDICATION ASSISTED TREATMENT		
9. OUD Medication-Assisted Detoxification ¹		11
10. OUD Medication-Assisted Treatment Outpatient ²		2260

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 11/15/2024]

¹ OUD Medication-Assisted Treatment Detoxification includes hospital detoxification, residential detoxification, or ambulatory detoxification services/settings AND Opioid Medication-Assisted Treatment.

² OUD Medication-Assisted Treatment Outpatient includes outpatient services/settings AND Opioid Medication-Assisted Treatment.

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

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Table 21 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: 30-Day Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. 30-day Alcohol Use	<p>Source Survey Item: NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from [DATEFILL] through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?[Response option: Write in a number between 0 and 30.]"</p> <p>Outcome Reported: Percent who reported having used alcohol during the past 30 days.</p>		
	Age 12 - 20 - CY 2021 - 2022		<input type="text"/>
	Age 21+ - CY 2021 - 2022		<input type="text"/>
2. 30-day Cigarette Use	<p>Source Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you smoke part or all of a cigarette?[Response option: Write in a number between 0 and 30.]"</p> <p>Outcome Reported: Percent who reported having smoked a cigarette during the past 30 days.</p>		
	Age 12 - 17 - CY 2021 - 2022		<input type="text"/>
	Age 18+ - CY 2021 - 2022		<input type="text"/>
3. 30-day Use of Other Tobacco Products	<p>Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you use [other tobacco products]^[1]?[Response option: Write in a number between 0 and 30.]"</p> <p>Outcome Reported: Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (cigars, smokeless tobacco, pipe tobacco).</p>		
	Age 12 - 17 - CY 2021 - 2022		<input type="text"/>
	Age 18+ - CY 2021 - 2022		<input type="text"/>

4. 30-day Use of Marijuana	Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?[Response option: Write in a number between 0 and 30.]" Outcome Reported: Percent who reported having used marijuana or hashish during the past 30 days.		
	Age 12 - 17 - CY 2021 - 2022		<input type="text"/>
	Age 18+ - CY 2021 - 2022		<input type="text"/>
5. 30-day Use of Illicit Drugs Other Than Marijuana	Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use [any other illicit drug]? ^[2] " Outcome Reported: Percent who reported having used illicit drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, hallucinogens, inhalants, methamphetamine, and misuse of prescription drugs).		
	Age 12 - 17 - CY 2021 - 2022		<input type="text"/>
	Age 18+ - CY 2021 - 2022		<input type="text"/>

[1]NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.

[2]NSDUH asks separate questions for each illicit drug. The number provided combines responses to all questions about illicit drugs other than marijuana or hashish.

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

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Table 22 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. Perception of Risk From Alcohol	<p>Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk]"</p> <p>Outcome Reported: Percent reporting moderate or great risk.</p>		
	Age 12 - 20 - CY 2021 - 2022		<input type="checkbox"/>
	Age 21+ - CY 2021 - 2022		<input type="checkbox"/>
2. Perception of Risk From Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day? [Response options: No risk, slight risk, moderate risk, great risk]"</p> <p>Outcome Reported: Percent reporting moderate or great risk.</p>		
	Age 12 - 17 - CY 2021 - 2022		<input type="checkbox"/>
	Age 18+ - CY 2021 - 2022		<input type="checkbox"/>
3. Perception of Risk From Marijuana	<p>Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk]"</p> <p>Outcome Reported: Percent reporting moderate or great risk.</p>		
	Age 12 - 17 - CY 2021 - 2022		<input type="checkbox"/>
	Age 18+ - CY 2021 - 2022		<input type="checkbox"/>

Footnotes:

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Table 23 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Age of First Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. Age at First Use of Alcohol	<p>Source Survey Item: NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink. [Response option: Write in age at first use.]"</p> <p>Outcome Reported: Average age at first use of alcohol.</p>		
	Age 12 - 20 - CY 2021 - 2022		<input type="text"/>
	Age 21+ - CY 2021 - 2022		<input type="text"/>
2. Age at First Use of Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?[Response option: Write in age at first use.]"</p> <p>Outcome Reported: Average age at first use of cigarettes.</p>		
	Age 12 - 17 - CY 2021 - 2022		<input type="text"/>
	Age 18+ - CY 2021 - 2022		<input type="text"/>
3. Age at First Use of Tobacco Products Other Than Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product]^[1]?[Response option: Write in age at first use.]"</p> <p>Outcome Reported: Average age at first use of tobacco products other than cigarettes.</p>		
	Age 12 - 17 - CY 2021 - 2022		<input type="text"/>
	Age 18+ - CY 2021 - 2022		<input type="text"/>

4. Age at First Use of Marijuana or Hashish	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?[Response option: Write in age at first use.]" Outcome Reported: Average age at first use of marijuana or hashish.		
	Age 12 - 17 - CY 2021 - 2022		<input type="checkbox"/>
	Age 18+ - CY 2021 - 2022		<input type="checkbox"/>
5. Age at First Use Heroin	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used heroin?[Response option: Write in age at first use.]" Outcome Reported: Average age at first use of heroin.		
	Age 12 - 17 - CY 2021 - 2022		<input type="checkbox"/>
	Age 18+ - CY 2021 - 2022		<input type="checkbox"/>
6. Age at First Misuse of Prescription Pain Relievers Among Past Year Initiates	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [specific pain reliever] ^[2] in a way a doctor did not direct you to use it?"[Response option: Write in age at first use.]" Outcome Reported: Average age at first misuse of prescription pain relievers among those who first misused prescription pain relievers in the last 12 months.		
	Age 12 - 17 - CY 2021 - 2022		<input type="checkbox"/>
	Age 18+ - CY 2021 - 2022		<input type="checkbox"/>

[1]The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.

[2]The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

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Table 24 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. Disapproval of Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]"</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>		
	Age 12 - 17 - CY 2021 - 2022		<input type="text"/>
2. Perception of Peer Disapproval of Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]"</p> <p>Outcome Reported: Percent reporting that their friends would somewhat or strongly disapprove.</p>		
	Age 12 - 17 - CY 2021 - 2022		<input type="text"/>
3. Disapproval of Using Marijuana Experimentally	<p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]"</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>		
	Age 12 - 17 - CY 2021 - 2022		<input type="text"/>
4. Disapproval of Using Marijuana Regularly	<p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]"</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>		
	Age 12 - 17 - CY 2021 - 2022		<input type="text"/>
5. Disapproval of Alcohol	<p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]"</p>		

	Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 20 - CY 2021 - 2022		<input type="checkbox"/>

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

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**Table 25 – Substance Use Disorder Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use
Measure: Perception of Workplace Policy**

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
Perception of Workplace Policy	<p>Source Survey Item: NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?[Response options: More likely, less likely, would make no difference]"</p> <p>Outcome Reported: Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.</p>		
	Age 15 - 17 - CY 2021 - 2022		<input type="text"/>
	Age 18+ - CY 2021 - 2022		<input type="text"/>

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Table 26 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
Average Daily School Attendance Rate	<p>Source: National Center for Education Statistics, Common Core of Data: <i>The National Public Education Finance Survey</i> available for download at http://nces.ed.gov/ccd/stfis.asp.</p> <p>Measure calculation: Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.</p>		
	School Year 2021		<input type="text"/>

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Table 27 – Substance Use Disorder Primary Prevention NOMs Domain: Crime and Criminal Justice Measure: Alcohol Related Fatalities

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
Alcohol-Related Traffic Fatalities	<p>Source: National Highway Traffic Safety Administration Fatality Analysis Reporting System</p> <p>Measure calculation: The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.</p>		
	CY 2021		<input data-bbox="1304 625 1328 657" type="text"/>

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Table 28 – Substance Use Disorder Primary Prevention NOMs Domain: Crime and Criminal Justice Measure: Alcohol and Drug-Related Arrests

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
Alcohol- and Drug-Related Arrests	<p>Source: Federal Bureau of Investigation Uniform Crime Reports</p> <p>Measure calculation: The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.</p>		
	CY 2021		<input type="text"/>

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Table 29 – Substance Use Disorder Primary Prevention NOMs Domain: Social Connectedness Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. Family Communications Around Drug and Alcohol Use (Youth)	<p>Source Survey Item: NSDUH Questionnaire: "Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No]</p> <p>Outcome Reported: Percent reporting having talked with a parent.</p>		
	Age 12 - 17 - CY 2021 - 2022		<input type="checkbox"/>
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12-17)	<p>Source Survey Item: NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" ^[1][Response options: 0 times, 1 to 2 times, a few times, many times]</p> <p>Outcome Reported: Percent of parents reporting that they have talked to their child.</p>		
	Age 18+ - CY 2021 - 2022		<input type="checkbox"/>

[1]NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.
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Table 30 – Substance Use Disorder Primary Prevention NOMs Domain: Retention Measure: Percentage of Youth Seeing, or Listening to a Prevention Message

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
Exposure to Prevention Messages	<p>Source Survey Item: NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use]^[1]?"</p> <p>Outcome Reported: Percent reporting having been exposed to prevention message.</p>		
	Age 12 - 17 - CY 2021 - 2022		<input type="checkbox"/>

[1]This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context
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Reporting Period Start and End Dates for Information Reported on SUPTRS BG Tables 31, 32, 33, 34 and 35

Reporting Period Start and End Dates for Information Reported on Tables 31, 32, 33, 34 and 35

Please indicate the reporting period for each of the following NOMS.

Tables	A. Reporting Period Start Date	B. Reporting Period End Date
1. Table 31 – Substance Use Disorder Primary Prevention Individual-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2022	12/31/2022
2. Table 32 – Substance Use Disorder Primary Prevention Population-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2022	12/31/2022
3. Table 33 (Optional) – Substance Use Disorder Primary Prevention Number of Persons Served by Type of Intervention	1/1/2022	12/31/2022
4. Table 34 – Substance Use Disorder Primary Prevention Number of Evidence-Based Programs and Strategies by Type of Intervention	1/1/2022	12/31/2022
5. Table 35 – Total Substance Use Disorder Primary Prevention Number of Evidence Based Programs/Strategies and Total SUPTRS BG Dollars Spent on Substance Use Disorder Primary Prevention Evidence-Based Programs/Strategies	10/1/2021	9/30/2023

General Questions Regarding Prevention NOMS Reporting

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

We use the Mosaix IMPACT data collection system to collect all prevention related data.

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race.

Indicate whether the State added those participants to the number for each applicable racial category or whether the State added all those participants to the More Than One Race subcategory.

The state added those participants who identify as more than one race under the "more than one race" category in the report.

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Table 31 – Substance Use Disorder Primary Prevention Individual-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity

The reporting period for Tables 31 is Calendar Year (CY) 2022, which coincides with the reporting period for the prepopulated prevention NOMs in Tables 21-30. It is understood that some states have reported on the State Fiscal Year (SFY) or Federal Fiscal Year (FFY) for these tables in past SUPTRS BG Reports. If your state is unable to report on CY 2022, please indicate in this footnote why you are unable to report on the CY and the steps the state intends to take to make calendar year reporting possible in future years.

Category	Total
A. Age	384,980
0-5	5
6-12	160
13-17	116,336
18-20	47,006
21-24	3
25-44	207
45-64	204
65-74	247
75 and Over	0
Age Not Known	220,812
B. Gender	384,980
Male	73,048
Female	79,683
Trans man	0
Trans woman	0
Gender non-conforming	0
Other	232,249
C. Ethnicity	384,980
Hispanic or Latino	16,418
Not Hispanic or Latino	129,402
Ethnicity Unknown	239,160
D. Race	384,980
White	127,172
Black or African American	8,238
Native Hawaiian/Other Pacific Islander	42
Asian	4,272
American Indian/Alaska Native	783

More Than One Race (not OMB required)	5,415
Race Not Known or Other (not OMB required)	239,058

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Table 32 – Substance Use Disorder Primary Prevention Population-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity

The reporting period for Tables 32 is Calendar Year (CY) 2022, which coincides with the reporting period for the prepopulated prevention NOMs in Tables 21-30. It is understood that some states have reported on the State Fiscal Year (SFY) or Federal Fiscal Year (FFY) for these tables in past SUPTRS BG Reports. If your state is unable to report on CY 2022, please indicate in this footnote why you are unable to report on the CY and the steps the state intends to take to make calendar year reporting possible in future years.

Category	Total
A. Age	120073
0-5	0
6-12	2391
13-17	6417
18-20	50
21-24	0
25-44	0
45-64	0
65-74	0
75 and Over	0
Age Not Known	111215
B. Gender	120073
Male	13
Female	5
Trans man	0
Trans woman	0
Gender non-conforming	0
Other	120055
C. Race	120073
White	17
Black or African American	
Native Hawaiian/Other Pacific Islander	
Asian	
American Indian/Alaska Native	
More Than One Race (not OMB required)	251
Race Not Known or Other (not OMB required)	119805
D. Ethnicity	120073
Hispanic or Latino	18

Not Hispanic or Latino	
Ethnicity Unknown	120055

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Table 33 (Optional) – Substance Use Disorder Primary Prevention Number of Persons Served by Type of Intervention

The reporting period for Tables 33 is Calendar Year (CY) 2022, which coincides with the reporting period for the prepopulated prevention NOMs in Tables 21-30. It is understood that some states have reported on the State Fiscal Year (SFY) or Federal Fiscal Year (FFY) for these tables in past SUPTRS BG Reports. If your state is unable to report on CY 2022, please indicate in this footnote why you are unable to report on the CY and the steps the state intends to take to make calendar year reporting possible in future years.

Number of Persons Served by Individual- or Population-Based Program or Strategy

Intervention Type	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct		N/A
2. Universal Indirect	N/A	
3. Selective		N/A
4. Indicated		N/A
5. Total	0	\$0.00
Number of Persons Served¹	384,980	120,073

¹Number of Persons Served is populated from Table 31 - Primary Substance Use Disorder Prevention Individual-Based Programs and Strategies - Number of Persons Served by Age, Gender, Race, and Ethnicity and Table 32 - Primary Substance Use Disorder Prevention Population-Based Programs and Strategies - Number of Persons Served by Age, Gender, Race, and Ethnicity

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Table 34 – Substance Use Disorder Primary Prevention Number of Evidence-Based Programs and Strategies by Type of Intervention

The reporting period for Tables 34 is Calendar Year (CY) 2022, which coincides with the reporting period for the prepopulated prevention NOMs in Tables 21-30. It is understood that some states have reported on the State Fiscal Year (SFY) or Federal Fiscal Year (FFY) for these tables in past SUPTRS BG Reports. If your state is unable to report on CY 2022, please indicate in this footnote why you are unable to report on the CY and the steps the state intends to take to make calendar year reporting possible in future years.

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
 - Guideline 1:
The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and
 - Guideline 2:
The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and
 - Guideline 3:
The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to Identifying and Selecting Evidence-Based Interventions scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and
 - Guideline 4:
The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.

The Selective and Indicated Evidence-Based program Project SUCCESS was previously on the Federal List of Registry. We have worked with the developer and our evaluation team to ensure fidelity. All Universal Direct and indirect programs are found on other Evidence-Based Practices lists.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?

Mosaix IMPACT prevention data collection system and provider reports.

Table 34 - SUBSTANCE USE DISORDER PRIMARY PREVENTION **Number of Evidence-Based Programs and Strategies by Type of Intervention**

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selective	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	14	20	34	1	1	36
2. Total number of Programs and Strategies Funded	14	20	34	1	1	36
3. Percent of Evidence-Based Programs and Strategies	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

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Table 35 – Total Substance Use Disorder Primary Prevention Number of Evidence Based Programs/Strategies and Total SUPTRS BG Dollars Spent on Substance Use Disorder Primary Prevention Evidence-Based Programs/Strategies

The reporting period for table 35 is the 24- month expenditure period of the FFY 2022 SUPTRS BG award.

Reporting Period Start Date: 10/01/2021 Reporting Period End Date: 09/30/2023

	Total Number of Evidence-Based Programs/Strategies for IOM Category Below	Total Substance Use Block Grant Dollars Spent on evidence-based Programs/Strategies
Universal Direct	Total # 14	\$868,056.73
Universal Indirect	Total # 20	\$763,889.92
Selective	Total # 1	\$1,736,113.47
Indicated	Total # 1	\$104,166.81
Unspecified	Total #	
	Total EBPs: 36	Total Dollars Spent: \$3,472,226.93

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expenditures are for prevention totals without Research Development amounts. Percentages have been applied to each category and calculated by prevention staff within the department.

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Prevention Attachments

Submission Uploads

FFY 2025 Prevention Attachment Category A:		
File	Version	Date Added
(RI) FFY 2025 - CategoryA v1.pdf	1	10/24/2024 3:39:29 PM

FFY 2025 Prevention Attachment Category B:		
File	Version	Date Added

FFY 2025 Prevention Attachment Category C:		
File	Version	Date Added

FFY 2025 Prevention Attachment Category D:		
File	Version	Date Added

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State of Rhode Island



Strategic Plan for Substance Misuse Prevention 2020-2024

SECTION 1 - INTRODUCTION

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is the State Mental Health Authority and the Co- Single State Authority for Substance Misuse with the Executive Office of Health and Human Services for the purposes of substance misuse education, prevention, and treatment programs. All policy, planning and oversight of substance misuse education, prevention and treatment funded by the Substance Abuse Mental Health Services Administration are under the auspices of BHDDH.

Mission and Vision

BHDDH Mission Statement: To serve Rhode Islanders who live with mental illness, substance use disorder and/or a developmental disability by maintaining a system of high quality, safe, affordable, and coordinated care across a full continuum of services. BHDDH will promote the health, safety, and well-being of all Rhode Islanders by developing policies and programs that address developmental disabilities, mental illness, addiction, recovery, and community support.

Prevention Services Unit Mission Statement: The goal of the Prevention Services Unit is to promote use of evidence-based programs, policies and practices designed to prevent the onset of substance use disorder, delay initiation of use, promote healthy lifestyles and optimize well-being among individuals, families, and communities across the lifespan.

BHDDH Vision: To be a leader in the development of innovative, evidence-based programs that improve care delivery, strengthen the service delivery network, and best serve those who need assistance. In collaboration with our community partners, BHDDH will be a champion of the people we serve, addressing their needs in a timely, efficient, and effective manner.

Prevention Services Unit Vision: The Prevention Services Unit provides resources and leadership to a statewide network of substance use prevention providers who engage community partners from a wide range of local and state stakeholder groups. Six prevention strategies endorsed by the Center for Substance Use Prevention are being used in RI communities to prevent substance misuse across the lifespan: dissemination of information, prevention education, alternative activities, problem identification and referral, community-based processes, and environmental approaches. These strategies are delivered through programs, policies and practices aimed at individuals, families, and communities. These strategies focus on building up protections against substance misuse and reducing risks of substance misuse disorder.

Prevention services focus on intervening prior to the onset of a disorder and are intended to prevent the occurrence of the disorder or reduce risk for the disorder. Prevention is also about striving to optimize well-being.

BHDDH departmental leadership and key stakeholders, who have a vested interest in prevention, have collaborated to develop the following strategic prevention plan. The purpose of this plan is to outline BHDDH's primary goals and strategies to strengthen the infrastructure and to provide funding support at the State and community-level to prevent and reduce the use of alcohol, tobacco, and other drugs across the lifespan. The

strategic plan establishes goals and objectives, priority populations and substances to target with various funding streams administered by BHDDH. The plan incorporates data guided prevention-specific objectives and strategies from the larger, department wide 2019-2024 Strategic Plan and informs policy priorities for the Prevention Advisory Committee of the Governor’s Council on Behavioral Health.

Planning and Conceptual Framework

BHDDH utilizes a life span framework-across the Institute of Medicine (IOM) care continuum focusing on priority populations and activities, including but not limited to substance misuse prevention, mental health promotion, violence prevention and tobacco control to promote health and mental wellness in Rhode Island (RI). The life span (course, or stages) framework helps to explain health and disease patterns, particularly health disparities, across populations and over time.

BHDDH utilizes the Strategic Prevention Framework (SPF) developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) as its operational planning framework. The framework uses a five-step process to assess state and community prevention needs across the life span. The SPF is built on principles of outcomes-based prevention, a community-based risk and protective factors approach to prevention, and a series of guiding principles appropriate for use here in RI at the state and community levels. The SPF stresses the use of findings from public health research along with evidence-based prevention programs to build capacity across various geographies and populations to promote resilience and decrease risk factors in individuals, families, and communities. Cultural competency and sustainability are infused into each of the SPF steps outlined below.

The steps of the Strategic Prevention Framework require RI and its communities to systematically:

- Assess prevention needs based on epidemiological data
- Build prevention capacity
- Develop a strategic plan
- Implement effective community prevention programs, policies, and practices, and
- Monitor, evaluate and document outcomes

Equally important, BHDDH implements a population health model by integrating prevention and mental health promotion across behavioral health systems. This model aims to improve the health of the entire population and to reduce health inequities among population groups. By focusing on the integration of prevention and mental health promotion across the State’s behavioral health system, BHDDH is developing a stronger infrastructure to leverage efficiencies and opportunities for increased coordination, collaboration, and sustainability.

The plan reflects on-going efforts to use data, key stakeholder, and community participation to set goals and objectives; prioritize evidence-based programs, practices, and policies; coordinate activities; determine key data indicators and evaluation plans to measure outcomes; identify target populations to improve health equity and reduce disparities related to substance use and mental illness; and plan for the sustainability of infrastructures and activities. The aim of this plan is to provide a roadmap to:

- Increase the capacity of the state’s prevention workforce. This includes the following:
 - Recruitment of new employees and retention of the current ones to meet the need being generated by grants
 - Utilize outcome focused planning models such as the SPF
 - Implement evidence-based practices and evidence-informed practices to address priority needs established in this plan, among populations prioritized by this plan or identified by a funder
 - Increase knowledge of the changing requirements and needs of its communities
- Support key stakeholders, prevention providers and policy makers to understand, promote and work towards preventing and reducing substance use among youth and young people
- Create an integrated prevention service delivery system which incorporates a broader behavioral health approach

Developing an integrated behavioral health infrastructure is an on-going process. In 2016 the state moved from a municipal service planning and delivery model to a more sustainable regionally focused model. This revitalized regional structure has allowed for a widened life focus that is better suited for identification of population health needs and promotion of behavioral health equity in the state. The State aspires to provide equity by offering the highest level of behavioral health to all people and supporting concerted efforts for those who have experienced social and/or economic disadvantages. The details of the State’s amended strategic plan are presented below.

SECTION 2- RHODE ISLAND BHDDH PREVENTION INFRASTRUCTURE OVERVIEW

There are several important components of the State’s prevention infrastructure that play an important and distinct role in the substance misuse prevention system in Rhode Island. Each stakeholder group or project highlighted below supports the mission of BHDDH and has helped to provide strategic direction for this plan.

Substance Abuse Prevention and Treatment Block Grant Sub-Recipients - Substance Misuse Provider Network and Initiatives

- **Coastline Rhode Island Employee and Student Assistance Services (RISAS)** - RISAS has been providing school and community-based substance misuse prevention and early intervention services to Rhode Island schools and communities since 1987. RISAS is implementing Project SUCCESS, an evidence-based SAMHSA program, in over 40 Rhode Island middle and high schools. Project SUCCESS is comprised of the following key components:
 - Prevention Education Curriculum
 - Screening and Assessment for Services
 - Individual and Group Counseling
 - School Wide Awareness Activities
 - Parent Program

RISAS used the State Opioid Response (SOR) Grant funds to implement an opioid-specific module delivered to middle and high school students as an additional topic in the Prevention Education

Series. This is a state-wide approach to implementing a prevention strategy designed to increase perception of risk of harm.

Rhode Island Substance Abuse Prevention Act (RISAPA) - In 1987, the Rhode Island General Assembly passed the Rhode Island Substance Abuse Prevention Act (RISAPA) to promote comprehensive prevention programming at the community level. In 2017 Rhode Island revitalized the system for prevention. We have composed the system into a regional prevention coalition design which has been broken into 7 regions. The Regional Prevention Task Forces (RPTF) are primarily responsible for overseeing the planning and delivery of prevention activities within the municipalities that comprise the region. The regional coalition is comprised of multiple municipal substance abuse prevention coalitions who will retain their individual identity and continue to provide prevention services to their communities. The regional prevention coalition design provides administrative oversight, funding and other human, technical, or financial resources needed to support municipal task force contributions to a regional prevention plan, and it will act as the fiduciary and administrative agent.

The RPTF are funded for the following service outcomes: *Long Term Outcomes*- reduce misuse of alcohol, tobacco and other drugs among RI's cities and towns. *Intermediate Service Outcomes*- increased representation and engagement of six Core Sectors at the Regional and municipal level (community-based process) to support expansion in the number and type of evidence-based prevention practices within RI cities and towns; increase disapproval of use of alcohol, tobacco, and other drugs by school aged youth within the region; decrease access to tobacco products for individuals under the age of 21. *Short Term Service Outcomes*- the RPTF will support implementation of evidence-based practices in each of the member municipalities. The reach and dose of these interventions will create measurable change in knowledge, attitudes, or behaviors. Every municipality will implement merchant education among its' licensed tobacco retailers designed to reduce illegal sales to individuals under the age of 21.

The primary goal associated with funding the RPTF is to increase the use of evidence-based policies, practices, and programs by municipal substance abuse prevention coalitions within the region. Each municipality within the region will be engaged in community-based process (e.g., having an active municipal substance misuse prevention coalition in place) and disseminating information related to prevention of substance misuse and community trends in substance misuse including emerging trends.

Each municipality should be implementing at least one evidence-based practice focused on alternatives or environmental change that is congruent with their need and the community's culture and context. This will be accomplished through working with six core sectors and community stakeholders to identify needed strategies and interventions to prevention substance misuse based on a community level assessment of needs, resources, and readiness.

The RPTF will work with member municipal task force leadership to identify the need, a core sector partner with sufficient readiness and capacity to implement an evidence-based practice (EBP) selected from a list of approved strategies. The RPTF will be responsible for assisting the municipal partner in providing or securing funding and resources necessary to implement and sustain the selected EBP.

Synar- BHDDH is the designated state agency responsible for ensuring compliance with the federal Synar

Amendment which requires all states receiving SAPT Block Grant funding to have in place and enforce a state statute prohibiting the sale or distribution of tobacco products to individuals under the age of eighteen; to conduct an annual statewide survey of retail tobacco outlets to determine retailer compliance with the state statute; to report the results of the Annual Synar Survey in the Annual Synar Report; and to maintain a statewide retailer violation rate under 20% as a condition for receipt of SAPT Block Grant funding. Included in the Report is a detailed description of prevention efforts conducted by the prevention coalitions to reduce youth access to tobacco. Since 1998, consistent with state law (RIGL- 11-9-13) inspection and enforcement provisions, BHDDH has contracted with municipal police departments to assist in the Annual Synar Survey and to engage in ongoing enforcement of the State's youth access to tobacco statute.

Collaborating BHDDH Grants/Cooperative Agreements

FDA: BHDDH has been designated as Rhode Island's FDA State Tobacco Compliance Check Inspection Program contractor since 2011 conducting advertising and labeling and undercover buy compliance check inspections. Conducting an average of 1300 inspections per year, BHDDH has built extensive inspection histories with Rhode Island's tobacco retailers. These inspections have afforded us the opportunity to regularly update Rhode Island's active licensed tobacco retailer list which is the foundation for the Synar Survey sample.

Healthy Transitions (HT): RI has received two Healthy Transitions grants: 2014-2019 and 2020-2025. The 2014 grant funded two sites: CCA and Thrive Behavioral Health. These sites continue to provide services. The 2020 grant is funding two sites: one at the Providence Center and the other at Newport Mental Health. The HT programs at all four sites address the needs of youth and young adults ages 16-25 with Serious Emotional Disturbance (SED), Severe Mental Illness (SMI), including first episode psychosis, and who may also have co-occurring substance use disorders. These programs conduct outreach to help identify, engage, screen, refer, and provide services to youth and young adults in their communities. Services provided include several evidence-based practices delivered within the Coordinated Specialty Care (CSC) model.

Promoting the Integration of Health and Behavioral HealthCare (PIPBHC): The Rhode Island Promoting the Integration of Health and Behavioral HealthCare (PIPBHC) grant will target 1,000 children and their families, or adult members of families with children, who are currently experiencing or at risk for substance use disorder and/or co-morbid physical and mental health conditions. The model will follow a family-based treatment approach, aiming to prevent child maltreatment by addressing high-need, underserved, and vulnerable populations with wrap-around services and coordinated physical and behavioral healthcare. All members of a qualified family or household will be eligible for PIPBHC-funded services along the spectrum through prevention, treatment, and recovery.

Partnerships for Success (PFS): The Strategic Prevention Framework-Partnerships for Success II grant (PFS II) will address one of the nation's top substance misuse priorities; underage drinking among persons aged 12-20. The purpose of the grant is to prevent the onset and reduce the progression of substance misuse and its correlated problems while strengthening prevention capacity and infrastructure at the state and community level and ensuring that prevention strategies and messages reach the

identified target population. PFS II provides funding to 20 communities that have been identified as high need based on a selected set of indicators. The identified communities are Burrillville, Bristol, Central Falls, Charlestown, Cranston, East Greenwich, East Providence, Hopkinton, Johnston, Lincoln, Middletown, Narragansett, Newport, North Kingstown, North Providence, Portsmouth, Richmond, Warren, Warwick, and Woonsocket. The communities will implement a set of comprehensive, evidence-based practices and policies to address the priority problem. The anticipated total reach is 56,479 individuals ages 12-20.

Screening, Brief Intervention and Referral to Treatment (SBIRT): Rhode Island SBIRT will pre-screen 15,000 individuals over a five-year period; approximately 1,000 in year 1 and 3,500 in years 2-5. The screening will cover tobacco, alcohol, marijuana, and other drugs. Screenings will take place in primary care/health centers, urgent care centers, emergency departments, through community health teams, and at the Department of Corrections. This initiative complements the State's efforts to integrate physical and behavioral healthcare.

State Youth Treatment Implementation (SYTI): The Rhode Island State Youth Treatment Implementation (RI- SYTI) project will focus on increasing access to screening, assessment, treatment, and recovery services for adolescents ages 12-17 and young adults' ages 18-25 who are at risk of or are experiencing substance use disorders (SUD) and/or co-occurring substance use and mental health disorders. The project will provide services, including outreach, engagement, and treatment to 1,160 youth and young adults over a four-year period.

Internal and Interagency Planning and Advisory Groups

Prevention and Early Intervention Team - BHDDH has an internal planning infrastructure with the introduction of the planning and implementation teams. Joint planning is conducted by prevention and early intervention grants across substance use and mental health, promoting further behavioral health integration within the Division of Behavioral Health. The PEIT is tasked with tracking progress on implementing goals and objectives for the Departmental Strategic Plan and identifying any emerging objectives to include in the operations plans.

Prevention Advisory Committee - The PAC is a committee of the Governor's Council on Behavioral Health. The PAC provides recommendations to the Governor's Council which are integrated into the annual report to the Governor and to the state's federal block grant application. The group's goals are to broaden the focus of substance misuse prevention efforts, integrate partnerships in prevention; reach populations that have been hard to reach; integrate systems for better evaluation and data collection; define prevention within the Affordable Care Act (ACA); work to eliminate health disparities and stigma around mental health and substance use disorders; and coordinate efforts across state departments and community providers. The PAC is committed to strengthening and expanding the prevention workforce in Rhode Island.

Rhode Island's Governor's Council on Behavioral Health - The Rhode Island Governor's Council on Behavioral Health is the mental health and substance misuse planning council. It reviews and evaluates mental health and substance misuse needs and problems in Rhode Island. It stimulates and monitors the

development, coordination, and integration of statewide behavioral health services. The Council serves in an advisory capacity to the Governor.

Rhode Island State Epidemiology Outcomes Workgroup (SEOW) - The primary mission of the SEOW is to guide institutionalized data-driven planning and decision making relevant to substance use/abuse and mental health across Rhode Island. As such, the SEOW operates within the outcomes-based prevention framework, aiming to integrate prevalence and incidence data with risk and protective factors data into its decision-making process and policymaking at the state and community level.

Training, Technical Assistance and Workforce Development Partners

The Rhode Island Certification Board (RICB) - The RI Certification Board defines a baseline standard for all credentials offered. Providers are given recognition for meeting specific predetermined criteria in behavioral health services. The RI Certification Board has been a participating member in the International Certification & Reciprocity Consortium (IC&RC) since 1988. (IC&RC sets international standards for professional competencies in behavioral health and develops and maintains written examinations for each reciprocal credential offered.)

Rhode Island Prevention Resource Center (RIPRC) - The RIPRC is a centralized training and technical assistance (TTA) resource for Rhode Island substance misuse prevention providers designed to develop, expand, and improve the prevention workforce. The RIPRC fosters state and local collaboration to prevent substance misuse and other risk-taking behaviors in Rhode Island.

The Substance Use and Mental Health Leadership Council of RI (SUMHLC) - SUMHLC is a nonprofit membership organization funded through the treatment set aside within the Substance Abuse Block Grant. SUMHLC represents public and private alcohol and drug treatment, behavioral health, and prevention while promoting a collaborative, coordinated system of comprehensive community based mental health, substance misuse prevention and treatment services which include but are not limited to treatment and recovery focused training opportunities.

Evaluation Partners

University of Rhode Island - Cancer Prevention Center - The Prevention Research Center (CPRC) will work with the Regional Prevention Task Forces (RPTF), Partnerships for Success, and Student Assistance to administer the Rhode Island Student Survey in middle and high schools across the state. The data reports will be available on a BHDDH web-based system broken out by district and school.

University of Rhode Island - Community Research and Services Team - The Community Research and Services Team (CRST) provides process and outcome evaluation services related to the substance misuse prevention service system in the following areas:

- Assessing the efficacy of the Regional Task Force coalition model
- Determining fidelity in the Regional model
- Completion rates for the biannual RI Student Survey
- Effectiveness of Regional Task Force coalition in achieving capacity/infrastructural

- outcomes
 - Effectiveness of the specific evidence-based practices implemented and their impact on achieving behavioral outcomes
 - Effectiveness in accomplishing key sustainability tasks
 - Student Assistance evaluation
 - RI Prevention Resource Center evaluation

SECTION 3 - STATE SUBSTANCE MISUSE PREVENTION PRIORITIES BASED UPON THE 2019 RHODE ISLAND STATE EPIDEMIOLOGICAL PROFILE

BHDDH takes a comprehensive approach to setting priority substance abuse prevention goals and objectives which includes use of an internal planning team (PEIPT) as well as engagement of community stakeholders and partners. Key to this process is a review of state and community epidemiologic profiles developed by the State Epidemiology and Outcomes Workgroup. The prioritization process includes review of consequence, consumption and intervening variable/risk or protective factor data using analyses of magnitude, trends/benchmarking, and changeability. The output from these processes informs resource allocation and BHDDH’s external fund development strategies.

The most recent Rhode Island State Epidemiological Profile (State EPI Profile) was completed in 2019. The purpose of the profile is to inform and assist in data-driven state and community-level planning and decision-making processes relevant to substance use and mental health issues across the State of Rhode Island. The profile provides a comprehensive set of key indicators – micro level to macro level – describing the magnitude and distribution of:

- Substance use consumption patterns (alcohol, tobacco, and other drugs), as well as their negative consequences across the lifespan
- Potential risk and protective factors associated with substance use and mental illness
- Behavioral health outcomes across the State of Rhode Island

The profile is guided by an outcomes-based prevention framework, and as such, it identifies the specific areas of need by analyzing consequences of substance misuse and consumption patterns as well as related risk and protective factors from all ecological levels that helped to drive the strategic planning process.

The Substance Use and Mental Health in Rhode Island (2019): A State Epidemiologic Profile (“2019 State Epi Profile”) identifies key behavioral health findings based on national and regional data sets. This strategic plan incorporates and adopts a sub-set of these priorities which are then integrated, as appropriate, within the formulation of goals, objectives and activities described in this plan. Several factors lead to the selection of actionable priorities.

- Not all priorities or recommendations from the 2019 State Epi Profile are changeable within the time frame addressed with this current prevention strategic plan
- Some priorities are not changeable with primary prevention strategies
- Evidence-based or evidence informed interventions fundable with the primary prevention set aside of the Substance Abuse Block Grant may not exist to address the priority

the justification for the priorities noted in this plan. Time trend charts have been provided within the body of this plan. The link to the Profile is available at www.riprc.org.

A. CONSEQUENCES OF SUBSTANCE USE - Priority Consequences for 2020-2024 Strategic Plan for Substance Misuse Prevention

The following priority consequences will be targets for primary prevention strategies based on their severity as compared to US rates or troubling trends. They include:

- A. Diagnosis of substance use disorder as defined by the American Psychiatric Association's Diagnostic and Statistical Manual diagnosis of illicit drug substance use disorder
- B. Diagnosis of substance use disorder as defined by the American Psychiatric Association's Diagnostic and Statistical Manual diagnoses of alcohol substance use disorder
- C. Drug overdose, especially those attributed to opioids and prescription drugs

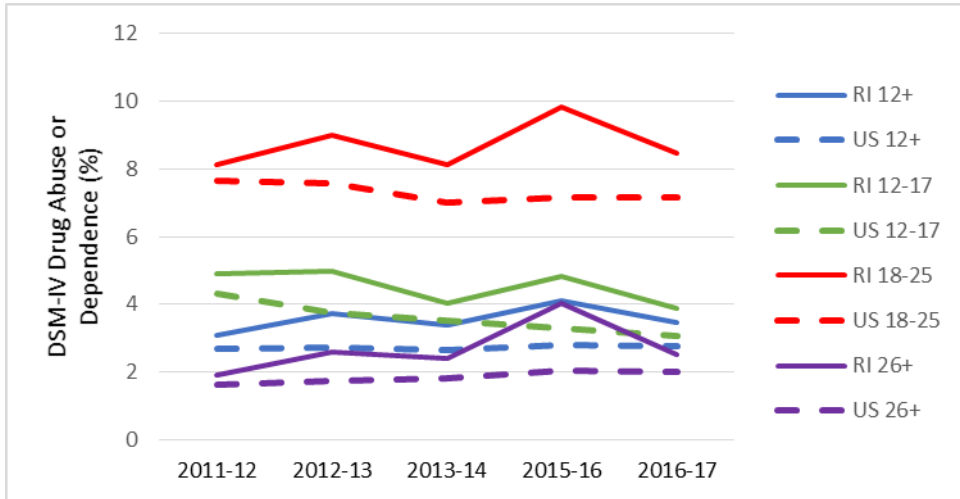
OBJECTIVE: The BHDDH 2020-2024 Strategic Plan contains the following objective related to overdose prevention: By December 2022, 100% of RI communities will sustain at least one activity promoting safer disposal practice previously funded by discretionary grants (Count It, Lock It, Drop It media campaign: prescription drug take back days; or permanent disposal sites) to prevent diversion of prescription opioids. This priority consequence objective is supported by data contained in the 2019 State Epidemiological Profiles as described below.

Strategies to support this objective include: (1) Increase the number of municipalities participating in drug take back days (expand to Scituate, North Smithfield, and Exeter); (2) Increase the number of permanent drug disposal sites (expand to Scituate, North Smithfield, and Exeter); and (3) Sustain the number of Regions implementing the Count It, Lock It, Drop It awareness campaign.

- D. Suicide attempts among adolescents - this is a Rhode Island Department of Health programmatic area where we collaborate

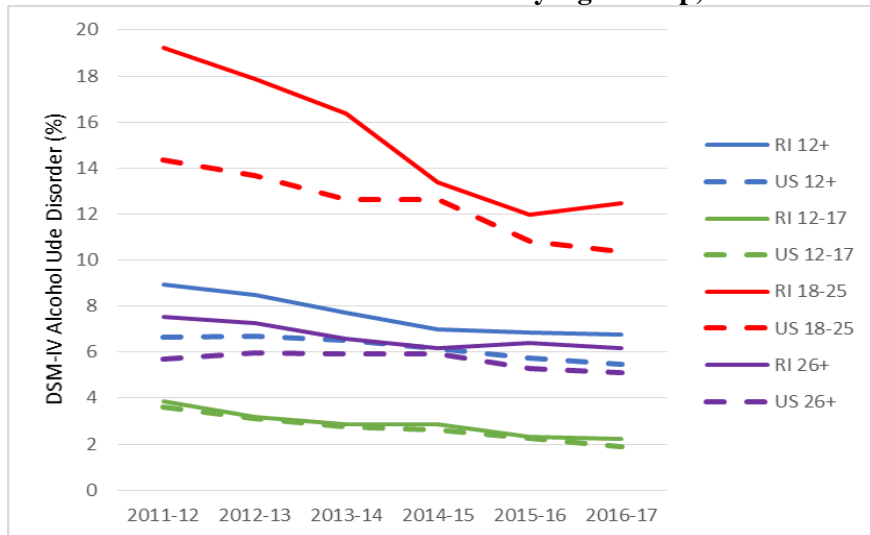
While a diagnosis of substance use disorder as defined by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) is potentially resolvable with primary prevention strategies, it will take considerably longer than the time frame covered in this strategic plan.

RI vs. US DSM Illicit Drug Abuse or Dependence by Age Group, 2011-2017



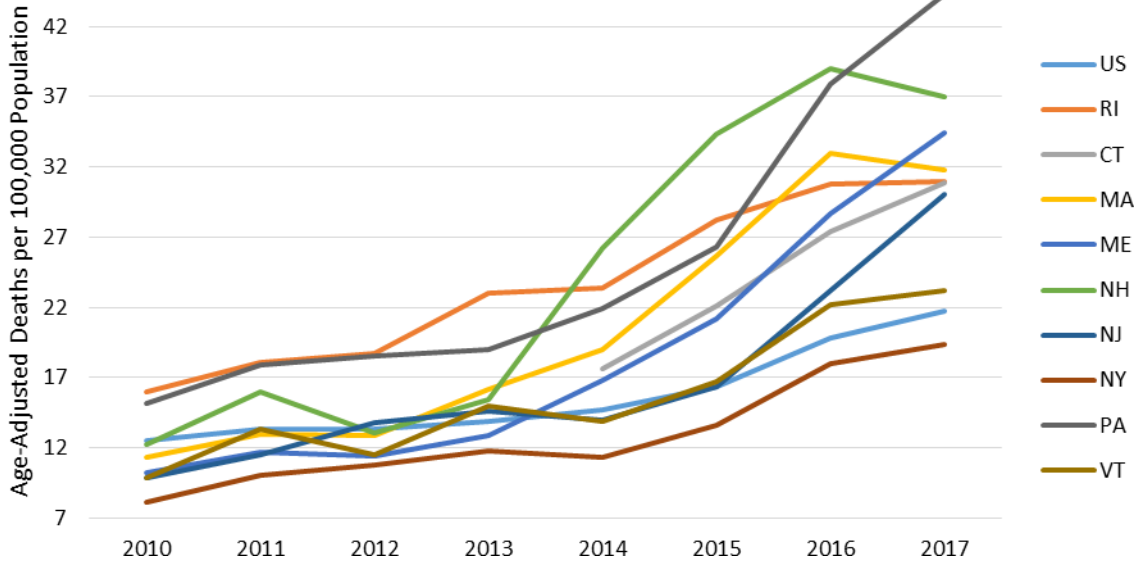
Source: National Survey on Drug Use and Health (NSDUH). Note: No data available for 2014-2015.

RI vs US DSM Alcohol Use Disorder by Age Group, 2011-2017



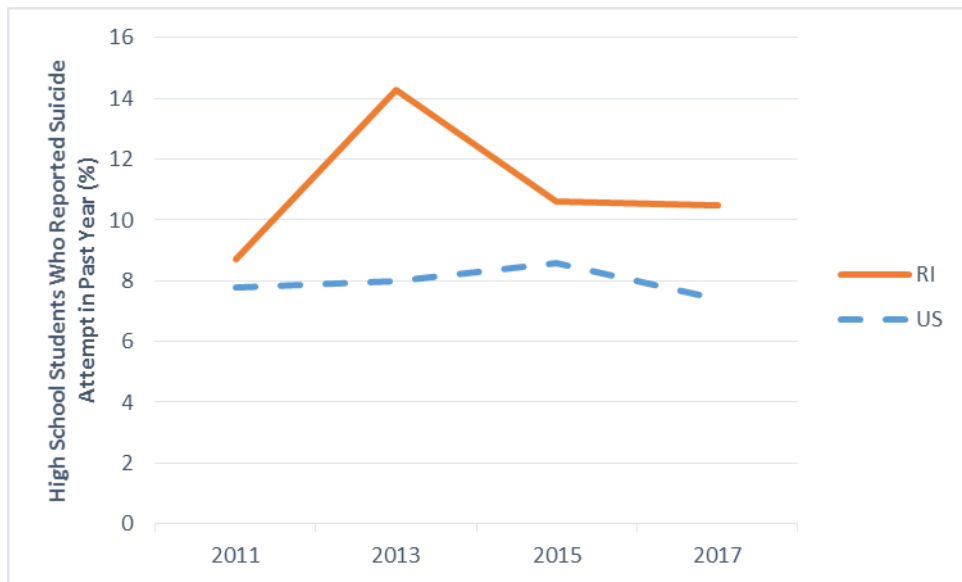
Source: National Survey on Drug Use and Health (NSDUH). Note: Indicator name changed from Alcohol Abuse or Dependence to Alcohol Use Disorder in 2014-15.

Figure 6. Drug-Related Overdose Deaths, 2010-2017



Source: Death certificate data: National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Mortality Detail files, 2010-2013. **2019 RI State Epi Profile.**

RI vs. US High School Students Grades 9-12 Who Attempted Suicide in the Past Year, 2011-2017



Source: Youth Risk Behavior Survey, Centers for Disease Control

Lastly, the percentage of youth who reported attempting suicide as compared to US percentages overall is slightly elevated¹. This selection of priority consequence is based on the ability to reduce suicide attempts by addressing shared risk and protective factors between substance misuse and suicide.

B. CONSUMPTION PATTERNS - Priority Consumption Patterns for 2020-2024 Strategic Plan for Substance Misuse Prevention

The following priority consumption patterns will be targets for primary prevention strategies based on their severity as compared to US rates, troubling trends or to maintain primary prevention efforts that have resulted in reductions in use or favorable trends in the right direction. BHDDH would seek a reduction on the magnitude of 3-4 % with consumption rates that exceed national averages so that RI rates are at or below national averages among those populations for which there is valid and reliable survey instruments that can be used at the sub-state level. The time frame in which measurable change would be expected is five to seven years, which extends beyond the time period covered by the plan. Where Rhode Island consumption patterns are at or below national averages, BHDDH will continue to implement efforts to maintain below national averages. The priority consumption patterns include:

- A. Use of marijuana 12-17
- B. Use of marijuana 18-20
- C. Problematic patter of use of marijuana 21-25
- D. Use of illicit drugs other than marijuana 12-17
- E. Use of illicit drugs other than marijuana 18-20
- F. Use of illicit drugs other than marijuana 21-25
- G. Underage drinking 12-17
- H. Underage drinking 18-20
- I. Binge drinking 21-25
- J. Youth use of tobacco or tobacco related products especially use of electronic nicotine delivery systems (ENDS).

Marijuana Use

OBJECTIVE: The BHDDH 2020-2024 Strategic Plan contains the following objective related to youth marijuana use: by September 2024 maintain or reduce marijuana use by ages 12-17 2016 baseline rates. This priority objective is supported by data contained in the 2019 State Epidemiological Profile as described below.

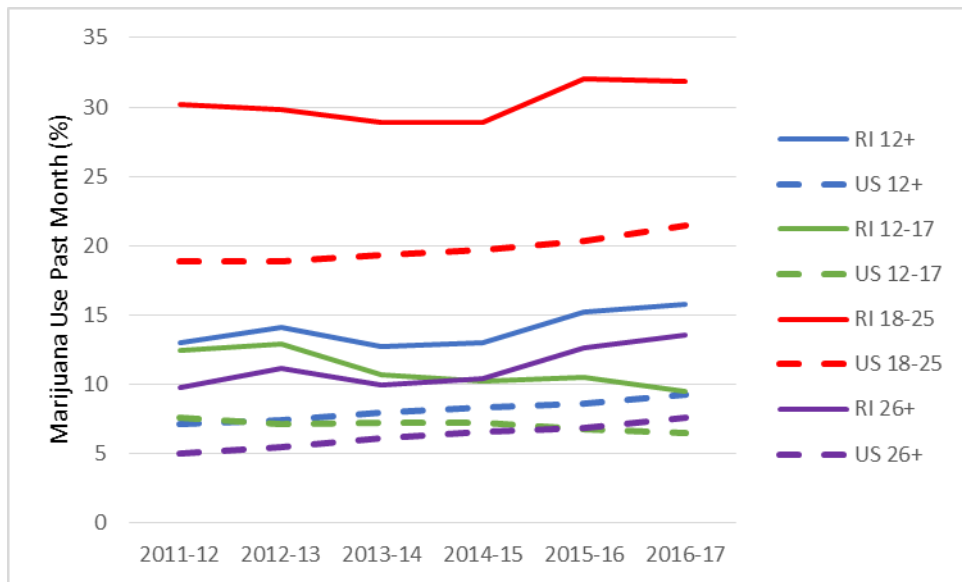
¹ Please note that the 2013 percentages reported in the chart above are believed to be an anomaly based on the RI Department of Health's review of other data for the same time frame

Strategies to support this objective are: (1) provide funding to Regional Prevention Task Forces to use information dissemination strategies to increase perception of risk of harm associated with marijuana use among adolescents ages 12-17 and their families; (2) provide funding to implement Project SUCCESS to implement (a) the Prevention Education Series as a grade-wide intervention to 7th and 9th graders, and (b) to support problem identification and referral in all RI school districts (both are components of Project SUCCESS).

Regarding findings related to youth marijuana use: relevant tables from the 2019 State Epidemiological Profile include Tables 2.1.1 and 2.2.0 featuring trend data from 2011-2012 to 2016-2017 from the Substance Abuse Mental Health Services Administration’s National Survey on Drug Use and Health, and Tables 2.1.9 and 2.2.3 from the Centers for Disease Control’s Youth Risk Behavior Survey which includes trend data from 2001-2015.

Major findings from the NSDUH are that RI has exceeded the national average for use across the life span since 2007-2008 by substantial margin of almost double the national rates in some age categories. These rates had significant decreases from 2012-2013 and 2013-2014 but the rates were still considerably higher than the national average.

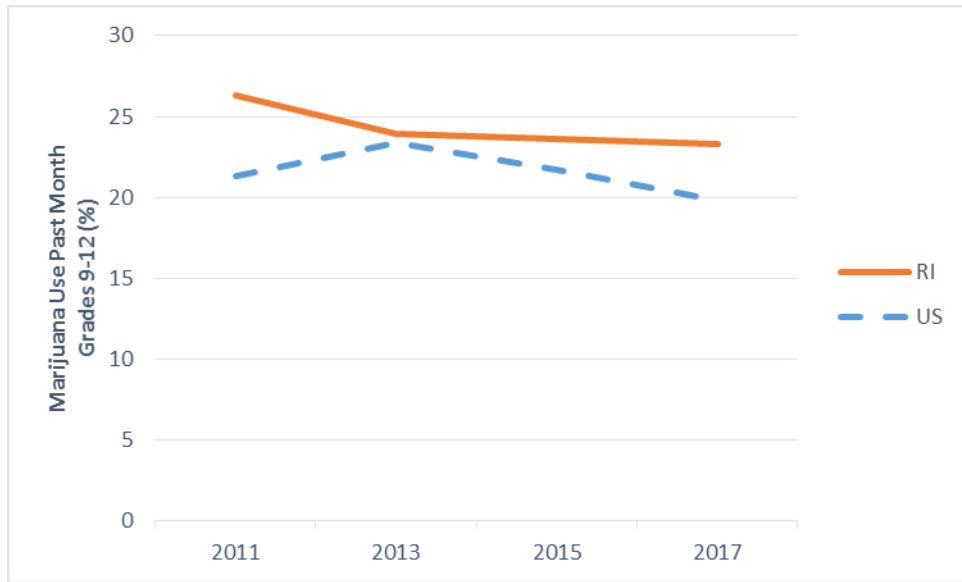
RI vs. US Marijuana Use Past Month by Age Group, 2011-2017



Source: National Survey on Drug Use and Health (NSDUH)

Primary prevention efforts to reduce marijuana use among adolescents may also produce beneficial effects among young adults over the long term as initiation primarily occurs prior to the age of 18. Various BHDDH managed funding streams have been targeting youth marijuana use since 2010 and as the chart above indicates, marijuana use among adolescents aged 12-17 has begun to decline after several years of increases even though it continues to be higher than national averages.

RI vs. US Youth Marijuana Use Grades 9-12, 2011-2017



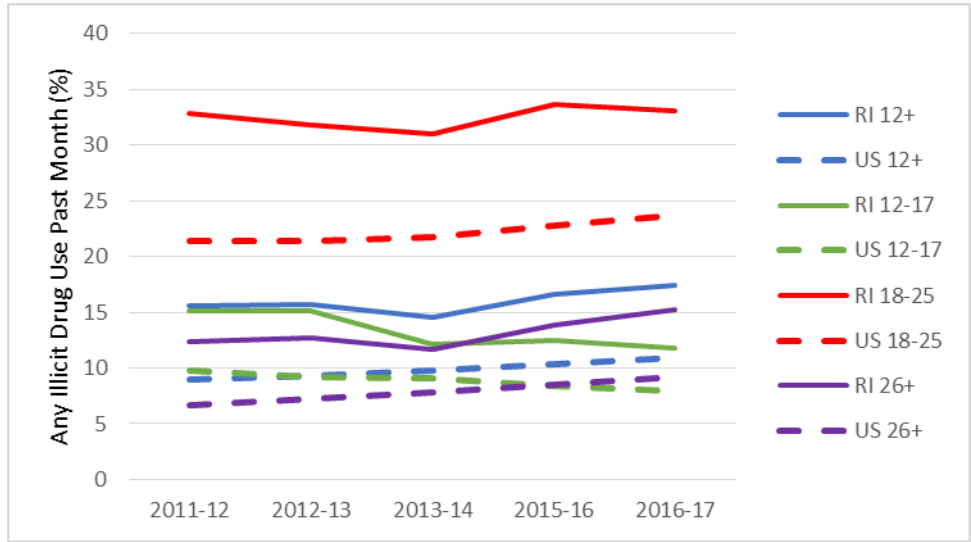
Source: Youth Risk Behavior Survey, Centers for Disease Control

The Youth Risk Behavior Survey results indicate that among a statewide sample of RI high school students, underage marijuana use prevalence – even though there was a decreasing trend from 2011 to 2017 – remained greater in Rhode Island than in the rest of the country. Rhode Island’s prevalence has remained stagnant since 2013, while the US percentage has been decreasing.

Illicit Drug Use

With respect to data from the National Survey on Drug Use and Health (NSDUH), past month illicit drug use prevalence among all age groups 12 years and older is higher among Rhode Islanders than the nation. 18 to 25-year olds in Rhode Island have much higher rates of illicit drug use than the national average. Both Rhode Island and the US have shown slight decreases in illicit drug use among 12-17 year olds from 2011 through 2016; yet, all other age groups have shown some increase over the same timeframe.

RI vs. US Any Illicit Drug Use Past Month by Age Group, 2011-2017



Source: National Survey on Drug Use and Health (NSDUH)

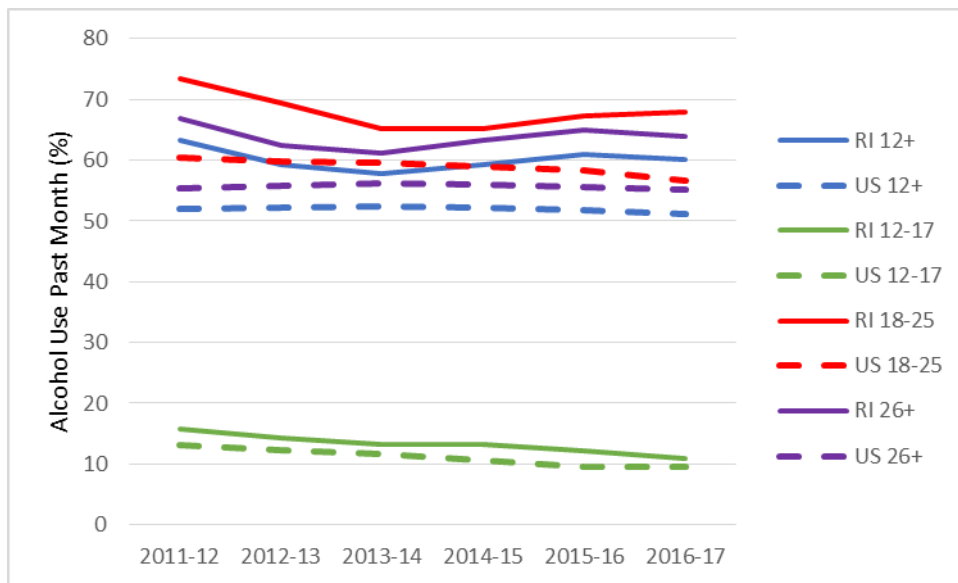
Underage Drinking and Past 30-Day Use Among Young Adults 18-25

OBJECTIVE: The BHDDH 2020-2024 Strategic Plan contains the following underage drinking objective: By September 2024 reduce prevalence of underage alcohol use by 3% over 2016 baseline. This priority objective is supported by data contained in the 2019 State Epidemiological Profile as described below.

Strategies to support this objective are: (1) provide funding to Regional Prevention Task Forces to use information dissemination strategies to increase perception of risk of harm associated with underage drinking among adolescents ages 12-17 and their families; (2) implement Project SUCCESS’ Prevention Education Series as a grade-wide intervention to 7th and 9th graders; and (b) to support problem identification and referral as part of Project SUCCESS in 31 RI school districts; and (3) use funding from the Partnerships for Success 2018 award to implement (a) educational strategies in school settings (middle school/junior high school, high schools and colleges/universities); (b) implement environmental strategies addressing social and retail access; and, (c) implement workplace interventions aimed at employers of 18-20 year-olds.

Rates of past month use of alcohol as reported in the NSDUH indicate that there is a downward trend for 12-17-year olds between 2011-2012 and 2016-2017 for both Rhode Islanders and the national average. However, since 2013-2014, data suggest a slow, but steady increase in past month alcohol use for all other age groups in Rhode Island. These slight increases in Rhode Island are not consistently reflected with the national average.

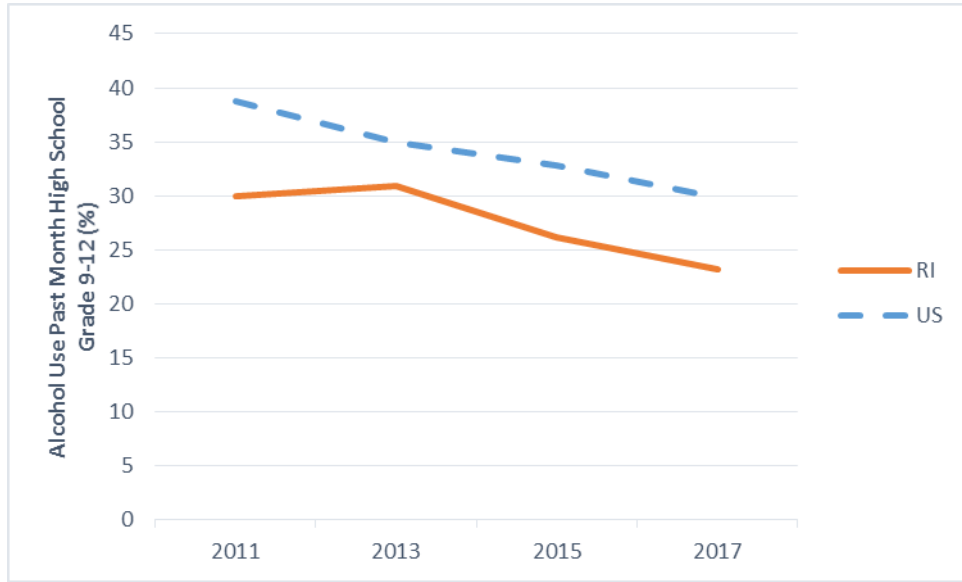
Alcohol Use Past Month by Age Group, 2011-2017



Source: National Survey on Drug Use and Health (NSDUH)

These results are consistent with those for high school youth reporting past 30-day use of alcohol on the YRBS with rates generally below the national average between 2011 -2017. Youth alcohol use rates, consistent with the national average, have been decreasing consistently since 2013.

Youth Alcohol Use Grades 9-12, 2011-2017



Source: Youth Risk Behavior Survey, Centers for Disease Control

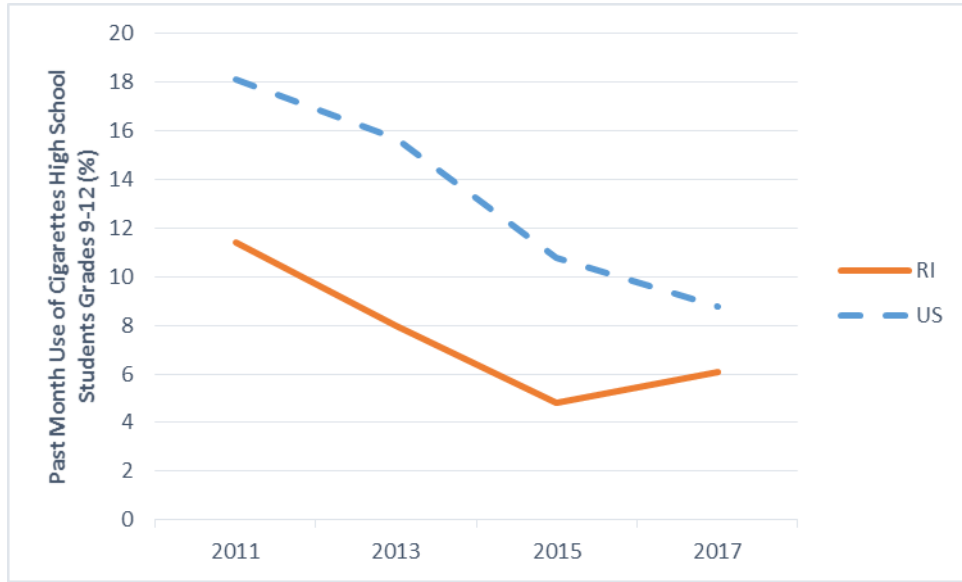
Youth Tobacco Use

OBJECTIVE: The BHDDH 2020-2024 Strategic Plan contains the following tobacco use objective: By December of 2024, the illegal tobacco sales violation rate for <18 will be maintained at or below 20% based on vendor education, point of sale ordinance or policy implementation of increased compliance checks. This priority objective is supported by data contained in the 2019 State Epidemiological Profile as described below.

Strategies employed to support this objective are: (1) provide funds to 7 Regional Prevention coalitions to implement either vendor education or point of sale ordinance or policies in RI cities and towns; and (2) conduct compliance checks and enforcement activities to insure that state laws prohibiting sales of tobacco products (conducted as part of the annual Synar survey) and select communities implement additional compliance checks; and (3) conduct compliance checks and other enforcement activities to ensure that Federal laws prohibiting sales of tobacco products are enforced (conducted as part of the Department’s FDA contract).

Since 2011 national trends for youth cigarette smoking have declined, and reduction in these consumption trends were consistent for Rhode Island. However, most recent 2017 YRBS data suggest that youth cigarette use may be increasing again—no longer consistent with the national trend—and likely warrants further investigation and continued monitoring.

Youth Tobacco Use (Cigarettes) Grades 9-12, 2011-2017



Source: Youth Risk Behavior Survey, Centers for Disease Control

C. RISK & PROTECTIVE FACTORS

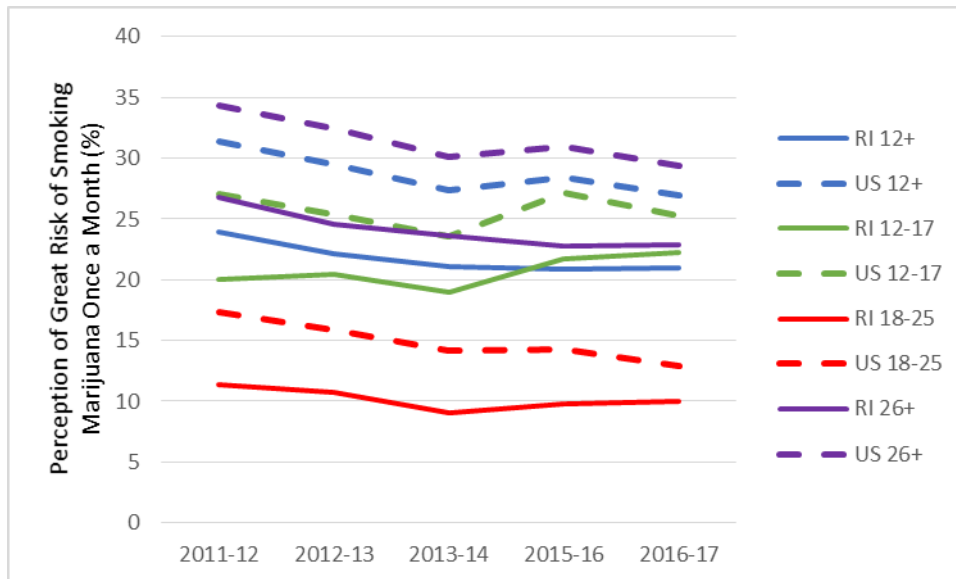
State or community level indicators related to behavioral health risk or protective factors are not as readily available as other indicators of consumption or consequences. The priority risk or protective factors are those that appear in research studies related to prevention of substance misuse. Currently, RI has limited access to risk or protective factor data, but efforts are being undertaken to address this gap through widespread use and implementation of the Rhode Island Student Survey, a risk and prevalence survey currently being administered bi-annually in all but four school districts.

BHDDH provides funds through the Substance Abuse Prevention and Treatment Block Grant to RI communities to implement strategies to address these risk and protective factors. In addition, twenty Rhode Island communities are currently receiving funding through the Partnerships for Success II (PFS II) grant in order to implement evidence-based practices to reduce underage drinking in youth and young adults ages 12-20. PFS II is a five-year, \$11,300,000 discretionary grant awarded by SAMHSA that will be funded through September 2023.

1. Priority Risk or Protective Factors
2. Perception of risk or harm

A major shared risk factor for misuse of substances is low perception of risk or harm. To that end, funded entities are charged with implementing information dissemination, environmental change (social marketing) and educational strategies focusing on increasing the perception of risk of harm associated with chosen priority substance(s).

RI vs. US Perceptions of Great Risk of Smoking Marijuana Once a Month by Age Group, 2011-2017



Source: National Survey on Drug Use and Health (NSDUH) **Note:** No data available for 2014-2015.

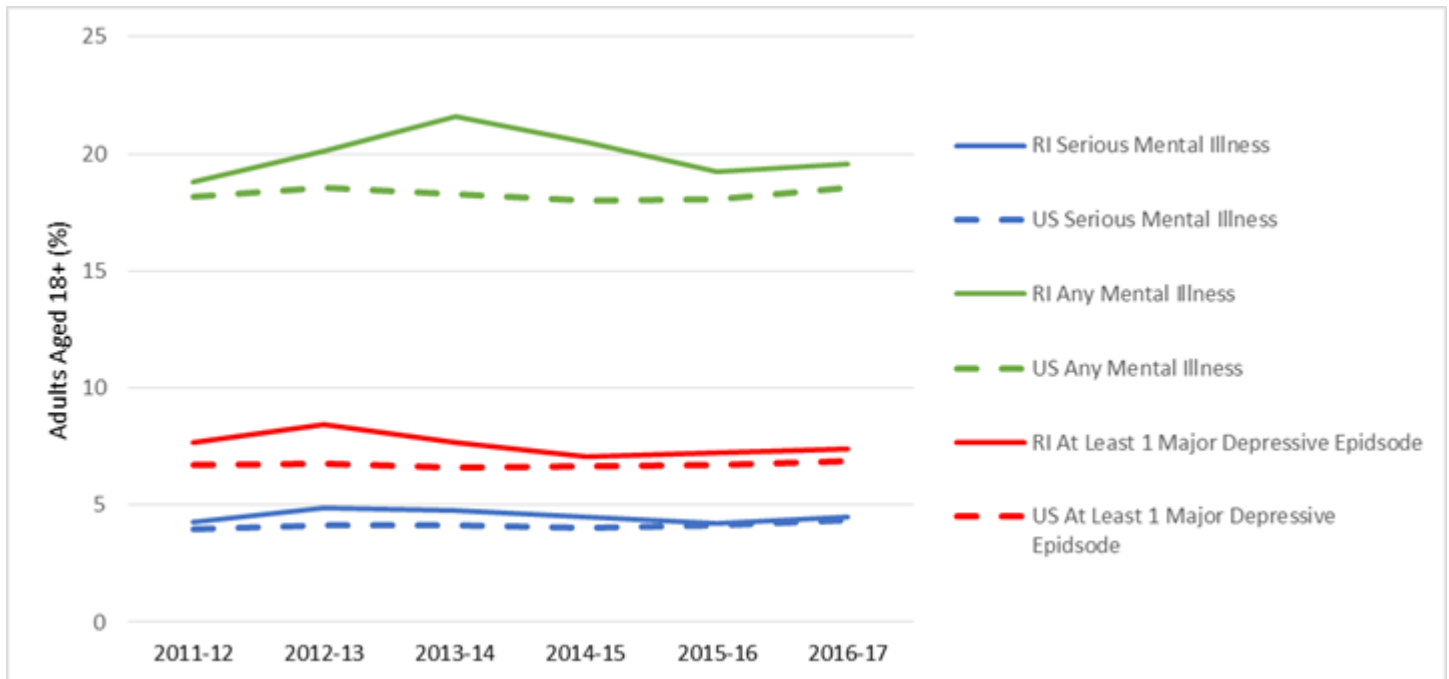
3. Access and Availability of Substances with Age Based or Other Conditional Use Restrictions

Use of alcohol and tobacco is restricted to adults, which is defined as 21 for alcohol and 21 for tobacco (as of July 7, 2021). Currently, marijuana possession and use are illegal in Rhode Island. In 2013 legislation was signed into law to decriminalize the personal possession of marijuana of up to one ounce by an individual 18 years or older as a non-arrestable civil offense, punishable by a maximum fine of \$150 but no jail time and no criminal record. In the case of medical marijuana, there may be some circumstances in which an underage individual has a medical marijuana card permitting possession or use of marijuana for medical purposes. In 2019 Governor Raimondo announced the possibility of adult legalization of marijuana in the near future. Funded entities are implementing environmental change strategies (policy/ordinance change; enforcement strategies: and enforcement strategies to curtail illegal retail or social access to targeted substances).

Other related risk or protective factors are derived from research literature or other reputable sources and can be targeted with funds based on departmental approval. Alternatives, when combined with other prevention strategies, are also utilized by some of the regional prevention task forces to address access and availability issues.

D. MENTAL HEALTH

RI vs. US Adult Past Year Mental Health, 2011-2017



Source: National Survey on Drug Use and Health (NSDUH)

RI has fared worse than most states in the region across all adult mental health indicators including past year serious mental illness, past year any mental illness, and having had at least one major depressive episode in the past year. RI had also consistently fared worse than the national average across adult mental health indicators.

In 2013-14, RI had the highest prevalence in the northeast region for any mental illness in the past year. However, in recent years 2014-15 through 2016-17, RI adult depressive episode and serious mental illness rates have moderately decreased, becoming comparable to the national rates. Having also decreased in RI, rates of any mental illness is still above the national average.

Efforts to include mental health promotion in the work of prevention coalitions should be a focus. Additionally, primary prevention efforts that also have positive outcomes related to suicide prevention across the lifespan should be a focus.

SECTION 4 - ALIGNMENT WITH SAMSHA'S STRATEGIC INITIATIVES

The priorities identified through the 2017 State Epidemiological Profile align well with SAMHSA's strategic initiatives, ensuring that BHDDH and its' state and community partners are continually improving and refining capacity to address these issues across the state. In addition, focusing on workforce development, creating/sustaining state and community partnerships and improving/enhancing use of data guided decision making will poise RI well to leverage discretionary funding from SAMHSA to expand our reach.

SAMHSA's Strategic Plan FY2019-FY2023

Priorities and goals related to prevention:

Priority 1: Combating the Opioid Crisis through the Expansion of Prevention, Treatment, and Recovery Support Services

Goal

Reduce opioid misuse, use disorder, overdose, and related health consequences, through the implementation of high quality, evidence-based prevention, treatment, and recovery support services

Priority 3: Advancing Prevention, Treatment, and Recovery Support Services for Substance Use

Goal

Reduce the use of tobacco (encompassing the full range of tobacco products and reduce the misuse of alcohol, the use of illicit drugs, and the misuse of over the counter and prescription medications and their effects on the health and well-being of Americans.

BHDDH prevention priorities, which are consistent with SAMHSA's priorities, most broadly reflect the following:

- Increase the capacity of the state's prevention workforce
- Support key stakeholders, prevention providers and policy makers to understand, promote and work towards preventing and reducing substance use across the lifespan
- Create an integrated prevention service delivery system which incorporates a broader behavioral health approach

SECTION 5 - STRATEGIC PLANNING GOALS AND OBJECTIVES

These strategic planning goals and objectives were developed based on input from the Prevention Advisory Committee (PAC), current epidemiological data and in context of an evolving prevention system revision process. The PAC held a series of four (4) strategic planning sessions during 2015 and early 2016 to help inform this Plan. In 2018, the PAC performed a Strength, Weakness, Opportunities and Threats (SWOT) analysis and provided this feedback to BHDDH. The goals and objectives, provided below, prioritize infrastructure development, workforce development and reduction of key risk factors identified in the state's EPI profile. BHDDH's prevention goals are designed to foster and monitor the supports, collaborations, and systems needed to meet the desired outcomes related to reducing risk factors and promoting protective factors.

A. SYSTEM-LEVEL INFRASTRUCTURE DEVELOPMENT:

***Goal One:** Sustain a substance use prevention and mental health promotion delivery system designed to support effective prevention initiatives and leverage cost and resource efficiencies.*

Objective I: Ongoing 2021-2024 Task 4 – Implement, Monitor, Evaluate and Sustain Activities within Regional Prevention Strategic Plan and Municipal Work Plans

***Goal Two:** Improve state and local prevention providers' ability to integrate substance use prevention and mental health promotion across behavioral health provider systems.*

Objective I: By Dec 31, 2021 (and for each year after) RIPRC will document the surveillance of current providers for prevention and mental health promotion on the state and community level(s) to ensure contract deliverables are being met and document the integration of behavioral health across prevention initiatives through the production of an annual summary report presented to the PAC and to the Governor's Council on Behavioral Health. The summary report will document the integration of mental health promotion in substance use prevention initiatives across the following state and community level organizations:

- a) State-level:
 1. State Epidemiology Outcomes Workgroup (SEOW)- incorporate mental health data into epidemiological profile
 2. RI Prevention Resource Center (RIPRC)
 3. Evidence-based Practices Workgroup
- b) RI Substance Abuse Prevention Act (RISAPA)/Regional Prevention Task Force Grantees
- c) Partnerships for Success (PFS) Grantees
- d) RI Student Assistance Service (RISAS) Grantee- measure mental health promotion
- e) State Opioid Response Grantees specific to prevention

Objective II: Groups addressing behavioral health issues will maintain meeting schedules and provide meeting feedback to the Prevention Advisory Committee. Each meeting will specifically identify opportunities to address the following: 1) to increase communication across the sectors; 2) to identify

increased opportunities for collaboration across sectors; 3) to ensure promotion of existing prevention services and initiatives and 4) to document the integration of prevention and mental health promotion across behavioral health provider systems.

Meetings will include and meet as follows:

- a) Governor’s Council on Behavioral Health: Monthly
- b) SEOW: Quarterly
- c) RI Prevention Certification Board: Quarterly
- d) RISAPA RPTF Grantees: Bi-monthly
- e) PAC: Bi-monthly
- f) PFS: Monthly
- g) RISAS: Quarterly
- h) Evidence-based Practices Workgroup: At least quarterly
- i) Children’s Cabinet- Monthly
- j) Governor’s Overdose Task Force Prevention Strategy Workgroup- Monthly
- k) Opiate PULSE meetings- Quarterly
- l) SBIRT Best Practices Group- Monthly
- m) Family Task Force SYT-1- Monthly
- n) Family Collaborative SYT-1- Monthly

Objective III: By July 31, 2022, BHDDH will update, based on recommendations from the evidence-based workgroup, data-driven, promising and evidence-based practice decision supported tools for all funded prevention providers in order to meet the requirements outlined in the strategic plan.

Objective IV: BHDDH requires that each prevention program implement at least one Evidence Based Program or Practice. Each Regional Prevention Task Force Coalition contract and each student assistance service contract must use at least one Evidence Based Practice.

Goal Three: *BHDDH and/or a contracted provider will convene and staff the Rhode Island Prevention Advisory Committee (PAC), a committee appointed by and accountable to the RI Governor’s Council on Behavioral Health.*

Objective I: By July 31, 2024, the PAC will recruit and maintain 80% of required representatives appointed by the Governor’s Council on Behavioral Health and maintain a minimum of 15 professionals representing a broad range of content expertise, including but not limited to required representatives (*refer to list below*). Examples of organizations representing these areas of content expertise are italicized.

The purpose of the PAC is to coordinate the State’s strategic efforts to reduce the incidence and prevalence of ATOD (Alcohol, Tobacco, and Other Drugs) misuse and abuse, as well as provide leadership and continuity to advance ATOD prevention and mental health promotion (MHP).

- 1) BHDDH Prevention and Planning Unit*

- 2) Department of Health (HEALTH) and/or Community Violence Prevention and/or Suicide Prevention*
- 3) RI Substance Abuse Prevention Act (RISAPA)* – *Regional Prevention Task Force Coalitions*
- 4) Certified Prevention Specialist*
- 5) Student Assistance Program*
- 6) State Epidemiological Outcomes Workgroup (SEOW)* – *Epidemiologist Contractual Lead*
- 7) Department of Youth and Family Services Prevention Specialist/Family Community Care Partnership Representative (s)
- 8) Military Prevention – *National Guard*
- 9) School-based Healthcare – *School Nurse Association*
- 10) Community/School Health Educator (s) – *Teacher’s Association*
- 11) Physical Healthcare Provider (s) – *Physician’s Association*
- 12) Parent Organizations – *Parent/Teacher Association, Mothers Against Drunk Driving, Mentor Rhode Island, Rhode Island Parent Information Network (RIPIN)*
- 13) Law Enforcement – *Community Police*
- 14) Tobacco Control Prevention Specialist (s) – *American Lung Association*
- 15) Recovery – *RICAREs, Anchor*
- 16) Treatment – *Substance Use and Mental Health Leadership Council (SUMHLC)*
- 17) Developmental Disabilities – *RI Developmental Disabilities Council*
- 18) RI Department of Education
- 19) Youth Organizations – *Youth Pride, Students Against Destructive Decision Making (SADD), Youth in Action, Mentor Rhode Island, Rhode Island Parent Information Network (RIPIN) Youth Advisory Council*
- 20) Mental Health Promotion – *Substance Use and Mental Health Leadership Council (SUMHLC)*
- 21) Evidence-based Practice Workgroup
- 22) Medicaid Payer Organization

Please note sectors followed by an asterisk (*) are required representatives and are appointed by the Governor’s Council on Behavioral Health.

Objective II: The Prevention Advisory Committee will meet specifically to 1) review current prevention research; 2) review prevention policy updates; 3) develop new prevention policies (as needed); 4) disseminate quarterly meeting notes and action items; 5) identify priority prevention areas; 6) disseminate information to key stakeholders; 7) submit recommendations regarding prevention priorities and policies to Governor’s Council on Behavioral Healthcare.

Objective III: By December 31st, 2021 (and for each year after), the Prevention Advisory Committee will assist BHDDH and the Governor’s Council on Behavioral Healthcare to document the deliverables outlined in the RI Strategic Plan for Substance Misuse Prevention in a written annual report.

Goal Four: *Develop and document a plan to improve state and local cross organizational collaboration among funded providers who implement prevention initiatives. The plan will be designed to document the improvement*

of local, regional and/or state infrastructures to provide effective and inclusive behavioral health services. Elizabeth Farrar will be responsible for developing this plan with assistance from the Governor's Overdose Task Force Prevention Strategy Workgroup.

Objective I: By July 31, 2023, develop and implement a state-wide inventory of behavioral health prevention services, regardless of funding source.

Objective II: By July 31, 2024, develop and implement a state-wide inventory of data collected which may inform prevention efforts, regardless of funding source.

B. WORKFORCE DEVELOPMENT AND SUSTAINABILITY:

Goal Five: Identify standard core competencies and skills required to implement effective prevention initiatives.

Objective I: By January 1, 2020, establish a modified prevention service delivery system which includes a multi-tiered classification of prevention providers. The classification will be based on the classification tiers designed by the RI Certification Board, to acknowledge and document the varying levels of content expertise within the prevention service delivery system.

The following list outlines the classification levels for prevention providers:

- Associate Prevention Specialist
- Certified Prevention Specialist
- Advanced Prevention Specialist

Objective II: By July 31, 2022, develop and disseminate a workforce development plan, which documents the criterion for a multi-tiered classification of prevention providers* and a plan to provide on-going professional development opportunities to increase the capacity of funded prevention providers.

Goal Six: Maintain and evaluate an effective substance use prevention and mental health promotion system.

Objective I: By June 30, 2022 (and every year after), BHDDH will work with an evaluator to develop an annual report utilizing prevention data to analyze and report on process and outcome measures to determine the effectiveness of the state's prevention and mental health promotion system and to make recommendations for improvement.

Objective II: By December 31, 2023 (and every year after), BHDDH will develop and/or update a sustainability plan to specifically outline prevention and mental health promotion programming, policies and initiatives or recommendations.

Objective III: By July 31, 2024, sustain and update a suite of training and performance monitoring tools

to guide on-going prevention program improvement.

Goal Seven: *Based on the current available behavioral health data, BHDDH will monitor processes to improve outcomes across prevention and mental health promotion programs.*

Objective I: Annually, 75% of the funded substance misuse prevention providers who have been in the field for 2 or more years are credentialed at the level of Certified Prevention Specialist.

Having a greater number of CPS will help to meet workforce development goals to increase the capacity, knowledge, skills and organizational development of prevention and mental health promotion providers to address complex substance use problems and consequences, as well as self-harming and adverse behavioral health consequences.

Objective II- Annually, 75% of the Regional Coordinators hold the Advanced Certified Prevention Specialist certification.

Having a greater number of ACPS will continue to give the regional model the capacity to have leadership who is highly proficient in prevention knowledge and the needed skill set to provide guidance to the municipalities.

RIPRC: Quarterly Reporting and Annual Report
RISAS Grantees: Monthly Reporting

Objective III: BHDDH, through a training and technical assistance contract, will provide a minimum of 2 face-to-face trainings, 1 e-learning course, and a minimum of 384 technical assistance (TA) contacts annually. The training provided will be based on the results of a needs assessment among providers. BHDDH will also provide a biennial state-wide prevention conference, PREVCON, through this training and technical assistance contract.

The purpose of the TA opportunities is to increase the capacity of providers to integrate substance use prevention and mental health promotion to decrease silos, increase cross-sector collaboration and plan, implement, evaluate, and sustain comprehensive, culturally competent, and relevant strategies.

Objective IV. Annually, 100% of the community prevention providers maintain 80% from the following sectors:

- Business*
- Education*
- Safety*
- Medical/health*

- Government*
- Community/family supports*
- Youth*
- Parent
- Media
- Youth-Serving Organization
- Religious/Fraternal Organizations
- Other Substance Misuse Organizations

* Sectors marked with an asterisk are contractually required.

Additionally, community prevention providers will ensure initiatives and coalitions are reflective of the communities they serve in terms of race, ethnicity, and socioeconomic status.

Objective V: After January 1, 2022, funded providers will address a minimum of one of the following priorities based on the results of the municipality's needs assessment and regional strategic plan:

(Selection of these priorities will be driven by local data and planning activities that align with SAMHSA and BHDDH priorities and set requirements.)

- a. Use of marijuana 12-17
- b. Use of marijuana 18-20
- c. Problematic patter of use of marijuana 21-25
- d. Use of illicit drugs other than marijuana 12-17
- e. Use of illicit drugs other than marijuana 18-20
- f. Use of illicit drugs other than marijuana 21-25
- g. Underage drinking 12-17
- h. Underage drinking 18-20
- i. Binge drinking 21-25
- j. Youth use of tobacco or tobacco related products especially use of electronic nicotine delivery systems (ENDS).

Objective VI: The Rhode Island Student Survey (RISS) is a risk and prevalence survey for youth in middle and high school. A risk and prevalence survey looks at a set of factors or conditions to which youth may be exposed that are associated with negative behavioral health outcomes and the extent to

which youth may report engaging in problem behavior. It explores substance use, bullying, depression, suicide, and violence. The RISS has been administered in 2016, 2018 and 2020 in 31 school districts throughout Rhode Island. The RISS currently has fifty-eight questions. There is no personally identifiable information associated with the RISS. The questions are arranged in a particular way and explore specific topic areas. To youth, in particular, it may seem like they are repetitive, but the questions actually probe different components or dimensions of the situation. For example, questions are asked about multiple substances of abuse such as alcohol, tobacco, marijuana, illicit and prescription drugs. The questions are also asked across several domains such as the individual him/herself, peers, family, school and community. For example, students are asked about their perception of risk or harm associated with levels of use for each substance. Students are also asked about their individual perceptions of wrongfulness of use, as well as their perception of disapproval of use by peers and parents. The questions are asked across each substance because, for example, low perception of risk by the individual and low disapproval of use of marijuana among peers and parents has been linked in research to a greater likelihood of youth marijuana use. The intention and purpose of the RISS is to identify areas where there are strengths that can be built upon and to put additional resources to those areas that need improvement. The data is reviewed in aggregate, not at the individual level. The data is not meant to identify individuals. There are other surveys administered in schools, but most do NOT allow for the ability to analyze data at the schooldistrict or community level. This data is crucial for planning prevention services especially when resources are scarce.

Objective VII: BHDDH selected a provider to create and administer a Rhode Island Young Adult Survey (RIYAS). The intention of this survey is to understand the alcohol consumption patterns of young adults, ages 18- 25, to measure prevalence, risk and protective factors and consequences related to alcohol and other drug use. The selected provider developed the Young Adult Survey which mimicked the RI Student Survey (RISS), with some adjustments made in order to focus on the 18-25 year old population. The RIYAS was administered in 2020 and is scheduled to be administered again in 2022. All surveys are web-based. Recruitment for the survey focuses on social media platforms such as Instagram, Facebook, and craigslist. Incentives are provided to those that participate in the survey. Like the RISS, the data will be reviewed in aggregate and all surveys will be de-identified.

Objective VIII: BHDDH will consult numerous relevant state and federal data sources to assess needs across the lifespan. In addition to the RISS and the YAS, BHDDH will consult the Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey (YRBS) to assess trends across the lifespan.

Objective IX: The Rhode Island Prevention Resource Center (RIPRC) will conduct a formal Needs Assessment of workforce needs among prevention providers once every two years. The results of this Needs Assessment will be used to inform the scope and intensity of training and technical assistance services needed to help funded recipients effectively utilize the SPF to select and implement the evidence-based strategies most likely to be efficacious in addressing local substance misuse priorities. These data will also be used to create a strategic workforce development plan that identifies specific and measurable outcomes for workforce recruitment, training and technical assistance, and retention, and ensures that training and technical assistance services are targeting the most pressing workforce needs. In addition, BHDDH has repurposed the Partnerships for Success (PFS) Needs Assessment tools to be used by the Regional Prevention Task Force Coalitions to develop their Regional Strategic Plans. The Regional

Prevention Task Force Coalitions will implement these Needs Assessments once every two years. The data collected will be part of the constellation of data sources utilized to design and implement prevention initiatives that use the most effective and appropriate evidence-based strategies for prevention.

Goal Eight: Using the results from the Rhode Island Department of Health, the RI Young Adult, RI Student and Synar Surveys, funded prevention providers will measure and document two outcomes associated with BHDDH's prioritized risk factors.

Objective I: Between January 1st, 2022 and December 31st, 2024, funded entities should increase the perception of risk of harm associated with the chosen priority substance by 10% among the target population.

Objective II. Between January 1st, 2022 and December 31st, 2024, funded entities should reduce the access or perceived ease of access among populations for whom possession, use or consumption is illegal by 10% among the target population.

OBJECTIVES	STRATEGIES	MEASURES
<ul style="list-style-type: none"> By September 2024 reduce prevalence of underage alcohol use by 3% over 2016 baseline. 	<p>(1) provide funding to Regional Prevention Task Forces to use information dissemination strategies to increase risk of harm associated underage drinking among adolescents ages 12-17 and their families; (2) implement Project SUCCESS' Prevention Education Series as a grade wide intervention to 7th and 9th graders; and (b) to support problem identification and referral as part of Project SUCCESS in 31 RI school districts; and (3) use funding from the Partnership for Success 2018 award to implement (a) educational strategies in school settings (middle school/junior high school, high schools and colleges/universities); (b) implement environmental strategies addressing social and retail access; and, (c) implement workplace interventions aimed at employers of 18-20 year-olds. 3) provide funding to Regional Prevention Task Forces to use environmental change strategies to restrict alcohol access for youth</p>	<p>Past 30-day use of alcohol (Source: RI Student Survey)</p> <p>Past 30-day use of marijuana (Source: RI Student Survey)</p> <p>Feeling sad or hopeless (Source: RI Student Survey)</p> <p># schools</p> <p># districts</p> <p># referrals made</p> <p># school policy changes</p> <p>Disapproval of use of alcohol, tobacco and other drugs (ATOD) RI (Source: Student Survey)</p>
<ul style="list-style-type: none"> By September 2024 maintain or reduce marijuana use by 12-17 at 2016 baseline rates 	<p>(1) provide funding to Regional Prevention Task Forces to use information dissemination strategies to increase risk of harm associated marijuana use among adolescents ages 12-17 and their families; (2) provide funding to implement Project SUCCESS' to implement (a) the Prevention Education Series as a grade wide intervention to 7th and 9th graders, and (b) to support problem identification and referral of in 31 RI school districts (both are components of Project SUCCESS). 3) provide funding to Regional Prevention Task Forces to use environmental change strategies to restrict marijuana access for youth</p>	<p># strategies proposed</p> <p>Reach of strategies (Source: Impact)</p>

<ul style="list-style-type: none"> By December of 2024, the illegal tobacco sales violation rate for <18 will be maintained at or below 20% based on vendor education, point of sale ordinance or policy implementation increased compliance checks. 	<p>i. (1) provide funds to 7 Regional Prevention coalitions to implement either vendor education or point of sale ordinance or policies in RI cities and towns; and (2) conduct compliance checks and enforcement activities to insure that state laws prohibiting sales of tobacco products (conducted as part of the annual Synar survey) and select communities implement additional compliance checks; and (3) conduct compliance checks and other enforcement activities to ensure that Federal laws prohibiting sales of tobacco products are enforced (conducted as part of the Department’s FDA contract).</p>	<p>% of tobacco retailers that sell tobacco to minors (Source- Synar Survey) # compliance checks # individuals trained</p>
<ul style="list-style-type: none"> By 2020, reduce opioid and prescription overdose deaths as well as deaths related to the nonmedical use of prescription drugs by 1/3, from 290 in 2015 to 159. By 2020, increase the percentage of prevention coalitions implementing overdose prevention activities 	<p>i. (1) Increase the number of municipalities participating in drug take back days (expand to Scituate, North Smithfield, and Exeter); (2) Increase the number of permanent drug disposal sites (expand to Scituate, North Smithfield, and Exeter); and (3) Sustain the number of Regions implementing the Count It, Lock It, Drop It awareness campaign.</p>	<p># of overdose deaths (Source: Medical Examiner, RI DOH) # individuals trained # individuals exposed to messages # events</p>

SECTION 6 - SUMMARY and CONCLUSION

BHDDH will use the strategic planning goals and objectives from Section 6 (Strategic Planning Goals and Objectives) to address the priority problems identified in the 2019 State Epidemiological Profile. While the Department strives to reduce the number of individuals who meet diagnostic criteria for substance use disorders, it is unlikely that the current primary prevention resources will have sufficient reach or intensity to produce a measurable change during the time frame covered in this strategic plan. BHDDH will measure change in the positive direction with risk or protective factors targeted within communities or regions on magnitude of 10% over baseline along a similar three-year cycle among those populations, again where there are available data to measure change at the community or regional level.

By focusing on the integration of substance use prevention and mental health promotion across the State's behavioral health system, BHDDH is developing a stronger infrastructure to leverage efficiencies and opportunities for increased coordination, collaboration, and sustainability. Rhode Island's behavioral health system, including the collection of data used to measure and monitor substance use prevention and mental health promotion at the municipality level (or sub-State geographies), is an on-going process. BHDDH is taking important steps to cultivate its infrastructure to develop, maintain, and ensure a solid foundation for prevention work moving forward.