Step 1: Overview of the State's Behavioral Healthcare System

Assess the strengths and organizational capacity of the system (MH, SUD, primary prevention for the specific populations. Roles of the MHA, SSA and other state agencies. Agencies that serve the population and how they address disparities.

State Health and Human Services Departments

The Rhode Island Executive Office of Health and Human Services (EOHHS) was established in 2007 to strengthen the publicly-funded health care system; increase efficiency, transparency and accountability of EOHHS and its departments; promote data-driven and evidence-based strategic decision making, analytical orientation, and EOHHS-wide training in data analysis; improve the customer experience; and integrate budget and finance. Under state law, EOHHS serves as "the principal agency of the executive branch of state government" (R.I.G.L. §42-7.2-2) responsible for managing the departments of: Health (DOH); Human Services (DHS); Children, Youth and Families (DCYF); and Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). These agencies provide direct services to nearly 306,000 Rhode Islanders as well as an array of regulatory, protective and health promotion services to our communities. Health and human services benefits represent $3.1 billion spending per year, or over 40 percent of the entire state budget.

In 2014, the State consolidated all behavioral health Medicaid funding under the Executive Office of Health and Human Services (EOHHS), therefore, the state has requested that BHDDH and EOHHS be co-designated as the State Single Agency between the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) and the Executive Office of Health and Human Services (OHHS), per the provisions established in 42 U.S.C § 300x30(a), solely for the purposes of calculating the Substance Abuse Prevention and Treatment Block Grant (SABG) maintenance of effort (MOE). Specifically, the designees, BHDDH and OHHS, are to be jointly designated as administering agencies for federal aid purposes; BHDDH remains the substance abuse authority (SSA) with sole responsibility for the activities outlined in the pertinent federal substance abuse laws and regulations, including 42 U.S.C § 300x-21 et seq. The General Assembly created this language legislatively in the 2017 legislative session and the State is awaiting approval from SAMHSA.

Health and Human Service Departments

Below is a brief overview of the organizational structure for the Departments of Health and Human Services Although all the EOHHS departments collaborate on programs; BHDDH and DCYF serve as the lead agencies on this combined application for mental health, substance abuse prevention and treatment; therefore, the agencies will be described in more detail in the following section.

The Rhode Island **Department of Health's** primary mission is to prevent disease and to protect and promote the health and safety of the people of RI. RIDOH is a diverse and interactive state agency with broad-ranging public health responsibilities. DOH's organizational structure includes the following Divisions: Academic Center; Community Health and Equity; Environmental Health; Health Equity Institute; Policy, Information and Communication; Preparedness, Response, Infectious Disease and

Emergency Medical Services and the State Laboratories and Medical Examiner. As RI has no local health departments, RIDOH coordinates public health activities across the state. Drug overdose prevention was identified as a top priority for RIDOH in 2011. RIDOH has a substantial history of planning, implementing, and evaluating state-wide programs and providing RI communities and policy-makers with data and technical assistance to prevent drug overdose.

The **Rhode Island Department of Human Services'** vision is to be an organization of opportunity, working together with other resources in Rhode Island to offer a full continuum of services for families, adults, children, elders, individuals with disabilities, and veterans. DHS administers the following programs: Affordable Care Coverage, Child Care Assistance Programs, Child Support, Disability Determination, Elderly Affairs, Emergency Assistance, Energy Assistance, General Public Assistance, Long Tern Support Services, Medicaid, Medicare Program Assistance, Refugee Programs, Rhode Island Works, Rehabilitative Services, Services for the Blind and Visually Impaired, SSI Assisted Living, SSI Supplemental Payment, Supplemental Nutrition Assistance Program (SNAP), and Veterans Programs.

The goals of DHS are to ensure families are strong, productive, healthy, and independent; adults are healthy and reach their maximum potential, children are safe, healthy, ready to learn and reach their full potential, elders and individuals with disabilities receive a full continuum of services to enhance their quality of life and Veterans are cared for and honored.

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospital's (BHDDH) mission is 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 the spectrum of behavioral health care and developmental services. To promote the health, safety and well-being of all Rhode Islanders by developing policies and programs that address the issues of mental illness, addiction, recovery and community support. The Department's vision is 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 use the system. In collaboration with our community partners, to be champions of the people we serve, addressing their needs in a timely, efficient and effective manner.

Department of Children, Youth and Families DCYF will fill in

1115 Waiver and Reinventing Medicaid

The RI Medicaid Reform Act of 2008 directed the State to apply for a "global" demonstration under the authority of Section 1115(a) of Title XIX of the Social Security Act. The Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration (1115 Waiver) established a new Federal-State agreement that provides the State with substantially greater flexibility than is available under existing program guidelines. The entire Medicaid program operates under this single 1115 Waiver. The State has used the additional flexibility afforded by the 1115 Waiver to redesign the State's Medicaid program to provide cost-effective services that will ensure beneficiaries receive the appropriate services in the least restrictive and most appropriate setting. Rhode Island submitted an 1115 Waiver Extension request to CMS in 2013. The 1115 Waiver Extension was approved in January 2014, effective through December 2018. The state is planning to submit to CMS a request for extension for an additional 5-year period by the end of calendar year 2017.

The RI 1115 Waiver promotes the objectives of Title XIX (Medicaid) by:

1. Increasing access to, stabilizing, and strengthening providers and provider networks available to serve Medicaid and low-income populations in the State
2. Improving health outcomes for Medicaid and other low-income populations in the State
3. Increasing efficiency and quality of care through initiatives to transform service delivery networks

The 1115 Waiver has three major program goals: to re-balance the publicly-funded long-term care system, to ensure all Medicaid beneficiaries have access to a medical home and to implement payment and purchasing strategies that ensure a sustainable, cost-effective program.

The Medicaid program is an essential part of the fabric of Rhode Island's health care system serving one out of four Rhode Islanders in any given year and nearly forty percent over a three-year period. It has achieved national recognition for the quality of services provided.

Managed Care Organizations

RI EOHHS is the single state agency for Medicaid and procures the services of qualified managed care organizations to arrange for and provide Medicaid covered benefits to eligible beneficiaries in Rite Care, Rite Care for children with special health care needs, Rite Care for children in substitute care, Medicaid Expansion, and Rhody Health Partners. The Medicaid managed care programis served by three contracted managed care organizations.

Rhode Island is strongly committed to managed care as a primary vehicle for the organization and delivery of Medicaid covered services to its eligible beneficiaries. Rhode Island has steadily increased the populations and services included in its managed care programs. When Medicaid began in the mid-1960s, the RI Medicaid program was modeled as a traditional indemnity fee-for-service (FFS) health insurance program. Throughout the years, the State has progressively transitioned from a payer to an active purchaser of care. Central to this process has been a focus on improved access and quality combined with cost management.

The State's initial Medicaid managed care program, RIte Care, began in 1994, enrolling over 70,000 low-income children and families. A key contractual element was the "mainstreaming" provision, requiring all Health Plans to ensure that if a provider accepts enrollees from commercial lines of business, they must also accept RIte Care enrollees without discrimination. Children in Substitute Care Arrangements were voluntarily enrolled in RIte Care in December 2000 and Children with Special Health Care Needs (CSHCN) were voluntarily enrolled in RIte Care in 2003. Enrollment for CSHCN became mandatory in 2008.

In 2008, voluntary enrollment in Rhody Health Partners was implemented for "Medicaid-only" persons with disabilities. In the fall of 2009, all Medicaid eligible "aged, blind, and disabled" (ABD) adults without third-party coverage (TPL, including Medicare) who resided in the community were required to either enroll in a Health Plan through the Rhody Health Partners program, or in the State's FFS Primary Care Case Management (PCCM) program, Connect Care Choice (CCC). Currently, there are more than 14,700 enrolled in the Rhody Health Partners Program and the fee-for-service based Connect Care Choice program has been phased out.

Pursuant to the Affordable Care Act (ACA) Rhode Island elected to extend coverage to the Medicaid

Expansion group of low-income adults without dependent children. In January 2014, EOHHS initiated enrollment of this group into managed care.

This progression of expanded enrollment in managed care is characterized by enrollment of populations with increasingly complex health needs. Over this period, the contractual requirements of Health Plans have also expanded in terms of program requirements and in covered benefits as the State has increased the performance requirements of Health Plans for managing the health care needs of complex populations.

There are three participating health plans in Rhode Island's Medicaid managed care program. In 2016, the State re-procured the system and added an additional provider, Tufts Health to the cadre of existing providers, Neighborhood Health Plan of Rhode Island (NHP), United Healthcare of New England (UHC). The table below shows the distribution of enrollment by product line and by health plan as of the end of March 2016.

Managed Care Enrollment as of March 31, 2016

	NHP	**UHC**	**Total**	***% of Total***
RIte Care	95,554	46,892	142,446	*61.4%*
Children with Special Health Care Needs	5,284	1,711	6,995	*3%*
Children in Substitute Care, including foster	2,250	0	2,250	*1%*
Medicaid Expansion	35,535	29,312	64,847	*28%*
Rhody Health Partners	7,051	7,709	14,760	*6.4%*
Combined Total	**145,674**	**85,624**	**231,298**	***100%***
% of Total	*63%*	*37%*	*100%*	

Under the provisions of Rhode Island's 1115 waiver, enrollment in managed care is mandatory rather than voluntary for each of these populations with one exception, that being children in legal custody of the State Department of Children, Youth and Families (DCYF) herein referenced as "Children in Substitute Care." For all groups, other than Children in Substitute Care, requirements for freedom of choice are met through the option to select from more than one plan.

Children in Substitute Care arrangements represent those in foster homes, group homes or in other DCYF-designated/approved living arrangements. For this group, enrollment in managed care is voluntary rather than mandatory. DCYF, as the legal guardian of these children, exercises choice as to whether these children are to be enrolled in managed care. Presently, these children are enrolled in one contracted MCO, Neighborhood Health Plan of Rhode Island.

Rhode Island continues to operate certain programs, these include:

- Rite Share - The RIte Share Program is the State's Premium Assistance Program under Medicaid where the State purchases employer-sponsored health insurance for RIte Care eligible low income working individuals and their families who are eligible for employer sponsored insurance but could not otherwise afford it. Currently, there are approximately 8,000 individuals in the RIte Share Program. Persons eligible for RIte Share are not enrolled in Medicaid managed care.
- PACE - The Program for All-inclusive Care for the Elderly (PACE) was implemented in December 2005. On average, 280 beneficiaries are enrolled in the State's fully-integrated program for frail elders who are Medicare and Medicaid Eligible (MME) beneficiaries.
- Rhody Health Options - EOHHS implemented the Rhody Health Options Program in the fall of 2013 to serve the ABD and Medicare and Medicaid Eligible (MME) populations.

The program builds on, improves, and integrates primary care, acute care, specialty care, behavioral health care and long-term services and supports to better meet the needs of the target populations. Approximately 30,000 Rhode Islanders over age 65 and individuals with disabilities/chronic conditions who have Medicaid coverage or Medicare and Medicaid coverage (dual eligibility) are eligible. As of June 2016, almost 22,000 individuals were enrolled in the Rhody Health Options Program in the Neighborhood Health Plan of RI.

In concert with CMS and NHPRI, EOHHS has implemented a three-way managed care contract for Medicaid-Medicare eligible or "duals" as part of CMS' Financial Alignment Demonstration (FAD). Enrollment in this program is voluntary.

- Rite Smiles - Rite Smiles is EOHHS' managed dental care program designed to increase access to, and the outcomes of, dental services provided to Medicaid- eligible children born on or after May 1, 2000.

Including Rhody Health Options and PACE, over 85% of the Medicaid population is enrolled in a Health Plan and covered services and populations account for just under 65% of Medicaid expenditures in SFY 2016. (In part this is because the clear majority of managed care enrollees are in the RIte Care program, which has a lower per member per month (PMPM) cost, than the elder or adult disabled populations.) Rhode Island's participating Medicaid Managed Care plans have consistently been ranked among the best in the nation by the National Committee for Quality Assurance (NCQA)

At the time of initial eligibility determination or re-certification, EOHHS makes available non-biased enrollment counseling to eligible persons who are not already enrolled in a Health Plan. Responsibilities of the counselors include the following:

- Educating the potential enrollee and his or her family, guardian or adult caregiver about managed care in general, including the option to enroll in a Health Plan; the way services typically are accessed under managed care; the role of the Primary Care Provider (PCP); and the responsibilities of the Health Plan member.
- Educating the potential enrollee and his or her family, guardian or adult caregiver about benefits available through the contractor's Health Plan, both in-plan and out-of-plan.
- Informing the potential enrollee and his or her family, guardian or adult caregiver of available Health Plans and outlining criteria that might be important when making a choice; e.g., presence or absence of an existing PCP or other providers in a Health Plan's network.
- Educating the potential enrollee and his or her family, guardian or adult caregiver about premium and copayment requirements (if applicable). EOHHS has sole authority for determining whether individuals meet the eligibility criteria specified and therefore are eligible to enroll in a managed care plan and for determining the individual's premium rate category. Following ninety (90) days after their initial enrollment into a Health Plan, Members are restricted to that Health Plan until the next open enrollment period, unless dis-enrolled by EOHHS.

Rhode Island's portal for application and enrollment in Medicaid is through Health Source Rhode Island (HSRI). At the time of application or at other times determined at the sole discretion of EOHHS, applicants or beneficiaries are offered the opportunity to select a Health Plan or another program option. Through the HSRI portal, eligible individuals are prompted to select a contracted Medicaid managed care organization.

During any period, there are persons who both gain and lose Medicaid eligibility. The following provides a frame of reference for the volume of new enrollees entering the system. New enrollment for the period April through June 2015 is shown below by eligibility group.

o Rite Care Children and Families	7,886
o Children with Special Health Care Needs	154
o Children in Substitute Care	119
o Rhody Health Partners	979
o Adults without Dependent Children/Medicaid	4,593
TOTAL	13,37

In order to provide Medicaid eligible with freedom of choice of health plan, EOHHS conducts an open enrollment period for all enrollees upon the execution and readiness determinations of successful bidders. EOHHS will send notices to all eligible members advising them of the open enrollment period and of their health plan options. EOHHS works closely with HealthSource Rhode Island, with consumer advisory groups and with other stakeholders to ensure members are aware of their right to choose and how to be informed about their options.

Maintaining a strong Medicaid system is an economic imperative for the State. Medicaid supports a healthier population, which provides businesses and employers with a healthier workforce and more predictability of publicly funded costs.

In order to address the goals of both setting the foundation for growth in the state's economy and building a sustainable Medicaid program for the future, in March 2015, Governor Gina Raimondo issued Executive Order 15-08, establishing the "Working Group to Reinvent Medicaid" to provide recommendations for a restructuring of the Medicaid program. Guiding this effort was the understanding that given the crucial role of the Medicaid program to the state, it is of compelling importance that the State conduct a fundamental restructuring of its Medicaid program that achieves measurable improvement in health outcomes for the people of Rhode Island and transforms the health care system to one that pays for outcomes and quality at a sustainable, predictable and affordable cost for Rhode Island taxpayers and employers.

The final report of the Working Group was issued on July 8, 2015. The Executive Summary from that report states the following:

This report builds on the foundation laid by the Reinventing Medicaid Act of 2015 to propose a transformative vision for Rhode Island Medicaid. In this Working Group's first report, we proposed a set of short-term cost-saving measures that were designed to be the first step on a path towards a payment and delivery system that promotes value, quality, health, and efficiency. Working with partners from the health care sector, the advocacy community, the business community at large, and the Executive Office of Health and Human Services, we now lay out a model for a reinvented publicly financed health care system in Rhode Island based on the following principles:

1. Pay for value, not for volume
2. Coordinate physical, behavioral, and long-term health care
3. Rebalance the delivery system away from high-cost settings
4. Promote efficiency, transparency, and flexibility

From these principles, we derive ten goals for Rhode Island's Medicaid program:

- Goal 1: Substantially transition away from fee-for-service models to a system where members get their care through provider organizations that are accountable for the quality, health outcomes and total cost of care for their members.
- Goal 2: Define Medicaid-wide population health targets, and, where possible, tie them to payments.
- Goal 3: Maintain and expand on our record of excellence—including our #1 ranking—on delivering care to children.
- Goal 4: Maximize enrollment in integrated care delivery systems.
- Goal 5: Implement coordinated, accountable care for high-cost/high-need populations
- Goal 6: Ensure access to high-quality primary care.
- Goal 7: Leverage health information systems to ensure quality, coordinated care.
- Goal 8: Shift Medicaid expenditures from high-cost institutional settings to community-based settings.
- Goal 9: Encourage the development of accountable entities for integrated long-term care
- Goal 10: Improve operational efficiency

Each of these goals is accompanied by specific, measurable objectives that can serve as targets to achieve along the way towards the vision of a reinvented Medicaid. In this new system, our Medicaid Managed Care Organizations (MCOs) contract with Accountable Entities which are integrated provider organizations that will be responsible for the total cost of care and healthcare quality and outcomes of an attributed population. This will require improved contracts with the MCOs that require them to innovate in value-based purchasing strategies, including enhanced capacity for provider-level quality measurement, risk adjustment, and total cost of care measures; shared savings and bundled payment methodologies; and innovative contracting strategies with hospitals, home care providers, and long-term care facilities that align their financial interests and performance metrics with those of the accountable entities—while ensuring access to medically appropriate care. We also envision a system in which case management and other member support resources are coordinated and funded through the Accountable Entity, to ensure that care is focused, aligned, and timely, and that both medical and non-medical needs of our members are met and addressed.

Structural Capacity of the Departments Responsible for the Adult and Youth Behavioral Healthcare System

The Department of Behavioral Healthcare, Developmental Disabilities and Hospital (BHDDH):

The mission of BHDDH is to serve Rhode Islanders who live with mental illness, substance use disorders and/or developmental disabilities by maintaining a system of high quality, safe, affordable and coordinated care across the spectrum of behavioral health care services; and to promote the health, safety and well-being of all Rhode Islanders by developing policies and programs that address the issues of mental illness, addiction, recovery and community support. The Department's vision is 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 use the system; and, in collaboration with our community partners, to be champions of the people we serve, addressing their needs in a timely, efficient and effective manner. BHDDH is comprised of three large Divisions:

The Division of Developmental Disabilities is responsible for planning, funding and overseeing a community system of services and supports for adults with developmental disabilities.
The Department believes that all Rhode Islanders deserve to live happy, healthy and fulfilling lives. Our work supports efforts across the state to expand opportunity and provide high-quality services for all Rhode Islanders. The Division of Developmental Disabilities funds a statewide network of community services and supports for Rhode Islanders living with developmental disabilities. These services are available through community provider agencies or through self-directed services. The Division ensures access to available resources in response to the unique needs of each person receiving services. It supports opportunities for meaningful roles in the community for people living with developmental disabilities, including opportunities for jobs at competitive wages. It works to achieve the terms of a 2014 federal consent decree and provide integrated employment and day services for individuals living with developmental disabilities. It supports person-centered planning, where individuals receiving services create a service plan matched to their unique interests and goals. It promotes human rights and protects the health and safety of individuals living with developmental disabilities through quality improvement initiatives and the licensing and oversight of service providers.

Rhode Island Community Living and Supports (RICLAS)

As one of Rhode Island's first community service providers for people with developmental disabilities, Rhode Island Community Living and Supports has over 25 years of experience in providing a network of support tailored to individual needs.

RICLAS is licensed by the State of Rhode Island as a provider of residential and day program services. RICLAS follows all applicable state laws and regulations, and receives oversight by the Office of Facilities and Program Standards and Licensure within BHDDH. The standards set by the Division of Developmental Disabilities (DDD) form the framework for the service system and are fully prescribed in rules and regulations.

RICLAS supports adult men and women in a variety of homes, apartments, and with day support services throughout the State. Trained and experienced staff advocate for individual rights, promote opportunities, and help people develop competencies in both residential and work activity settings.

Division of Hospitals: Eleanor Slater and Zambarano Hospitals

In the late 1800's, Rhode Island opened two hospitals – the State Hospital for Mental Disease and the State General Hospital— in what is now known as the Pastore Complex in Cranston. In 1905 the RI State Sanatorium opened in Burrillville to treat tuberculosis patients. The General Hospital and State Hospital for Mental Disease merged to become the Rhode Island Medical Center in 1962 and the name subsequently was changed to the Eleanor Slater Hospital in 1994.

Today, the Eleanor Slater Hospital System is still located on two campuses, Cranston and Burrillville. It is the state's only Long Term Acute Care Hospital (LTACH) with 284 beds. The hospital provides long-term acute and post-acute hospital level of care to patients with complex medical and psychiatric needs.

ESH strives to provide a treatment environment in which dignity, individuality, and respect are emphasized. In addition to diagnosis and treatment, the hospital focuses on issues of recovery and community integration. There is a very active performance improvement effort at ESH. Leadership, physicians, nurses, and rehabilitative staff collaboratively review all processes associated with operations and quality of care. When needed, processes are modified or redesigned with the goal of providing better care for patients along with improved operations. At ESH, everyone works to provide a seamless system of care.

Division of Behavioral Healthcare

Organizational Overview

Per RI General Law Title 40.1, the Director of the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is empowered as the State Mental Health Authority and as the Co-Single State Authority for Substance Abuse within the Executive Office of Health and Human Services for the purposes of determining the Maintenance of Effort for substance abuse education, prevention and treatment programs. The co-designation is a result of the State consolidating behavioral health Medicaid funding. All policy, planning and oversight of substance abuse education, prevention and treatment are under the auspices of the Division of Behavioral Healthcare. The Office of Facilities and Program Standards and Licensure, within the Executive Division of BHDDH, is responsible for the licensing of behavioral health, developmental disabilities and traumatic brain injury programs for the State of Rhode Island.

The overarching goals of the Division are to:

- Promote wellness and assure quality integrated treatment and prevention throughout the State with the vision that all Rhode Islanders will have the opportunity to achieve the best possible health, well-being, resiliency and recovery and;
- Ensure residents can live in communities free of problems related to substance misuse; and have access to effective prevention, early intervention, and treatment and support to recover from mental health and/or substance use problems that may develop over the lifespan so that they can live, learn and fully participate in their communities without discrimination when these conditions persist.

The Division is organized into 4 Units:

Policy, Planning and Intergovernmental Relations

The Policy and Planning Unit leads the development of plans, roadmaps, policies and procedures to guide and align the mission and vision of the Division of Behavioral Healthcare and ensure that all programs, policies and practices reflect our core values.

Research, Data, Evaluation and Compliance

The Research, Data, Evaluation and Compliance Unit is responsible for the promotion of data-driven decision-making for the improvement of quality of care, efficiency of service delivery and integrity of behavioral health programing.

Program Services and Community Engagement

The Program Services and Community Engagement Unit ensures that the state's behavioral healthcare service system is responsive to the needs of the consumers, families, allies, advocates and communities we serve by providing quality services based on evidence informed/evidence based best practices.

Contract Monitoring and Finance

All financial matters for the Division are processed through this Unit. These include: procurements, payments, contracts and fiscal management of grants.

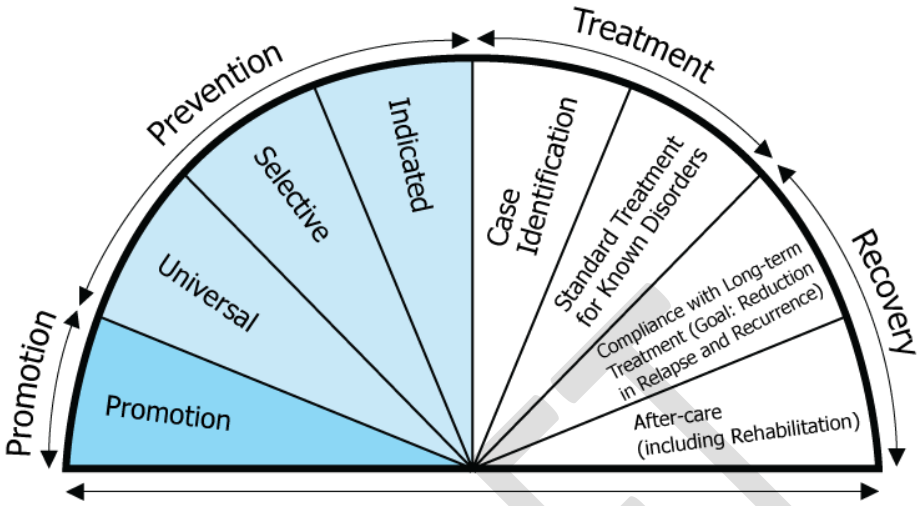
The Division's Units provide a comprehensive approach to attainment of six overarching goals. These goals are consistent with those of SAMHSA's National Behavioral Health Quality Framework and include:

1. Promote the most effective prevention, treatment and recovery practices for behavioral health disorders
2. Assure behavioral healthcare is person-centered with family involvement and connectedness to the community
3. Encourage effective coordination between behavioral healthcare and primary care and other healthcare, recovery and social supports
4. Support and encourage communities to use best practices to engage in healthy living
5. Make behavioral healthcare safe by identifying and reducing harm in any incidents of abuse, neglect and mistreatment in the delivery of care
6. Foster affordable, high quality behavioral healthcare through a new and recovery-oriented delivery model

The six broad goals are supported by an array of strategies aimed at priority populations and objectives consistent with SAMHSA's National Outcome Measures (NOMs).

Service System Overview

"Behavioral health" is a general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for mental and/or substance use disorders (SAMHSA Grant Glossary). The behavioral health service system exists on a continuum of Promotion of Mental Health and Prevention of Substance Use, Behavioral Health Treatment and Recovery Support services. **Diagram 1 –Institute of Medicine Continuum of Care**



Source: National Research Council and Institute of Medicine. (2009). Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities (O'Connell, M. E., Boat, T., & Warner, K. E., Eds.) Washington, DC: National Academies Press, p.67.

The Rhode Island Behavioral Health Service System includes the following service types:

Promotion and Prevention

Information Dissemination
Prevention Education
Environmental Approaches
Community-Based Processes
Alternative Activities
Problem Identification and Referral

Treatment and Support Services for Adults

General Outpatient Services
Integrated Dual Diagnosis Treatment
Medication Services
Laboratory Services
Case Management Services
Community Psychiatric Supportive Treatment
Intensive Outpatient Services
Integrated Health Homes
Assertive Community Treatment
Club Houses
Individual and Placement Services (ISP)
Illness Management
Peer Recovery Specialist
Community Integration Services
Supported Housing Services
Residential Services
Outpatient Detoxification Services
Medical Detoxification Services
Opioid Treatment Programs

Recovery Services

Recovery services include culturally and linguistically appropriate services that assist individuals and families working toward recovery from mental and/or substance use problems. They incorporate a full range of social, legal, and other services that facilitate recovery, wellness, and linkage to and coordination among service providers, and other supports shown to improve quality of life for people in and seeking recovery and their families.

The Department has adopted SAMHSA's definition of recovery services which also includes access to evidence-based practices such as supported employment, education, and housing; assertive community treatment; illness management; and peer-operated services. Recovery services may be provided before, during, or after clinical treatment or may be provided to individuals who are not in treatment but seek support services. These services, provided by professionals and peers, are delivered through a variety of community and faith-based groups, treatment providers, schools, and other specialized services.

The Department will be receiving technical assistance from SAMHSA regarding training as well as policy and procedure development for supervisors of Peer Recovery Specialists (PRS). RI has established an integrated (substance use disorder and mental health) approach to training and certification of PRSs. We are rapidly increasing our workforce but do not have a formal system for training and certifying supervisors of PRSs. Our goal is to have a formal PRS supervisor training in place as well as a supervisor certification process soon.

Adult Behavioral Healthcare System

Criterion 1: Comprehensive Community –Based Mental Health Service System: organized system of care for people with mental illness, including co-occurring Mental Illness/Substance Use Disorder that allow individuals to live in the community, outside of inpatient or residential institutions.

In accordance with RIGL 40.1-5, the RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals has the responsibility to license facilities and services for behavioral healthcare and developmental disability organizations. The Department works with 70 licensed providers, licenses 21 different services, and issues 789 licenses that are valid for a period of two years. The Department's Licensing Unit engages in regulatory enforcement and reform to improve participant centered practice throughout the provider community. As part of the regulatory reform process, the Licensing Unit works with stakeholders to ensure that the regulations are supporting, rather than hindering, individualized support for participants receiving services under the jurisdiction of BHDDH.

The definition of a ***"Behavioral Healthcare Organization"*** is a public or private establishment primarily constituted, staffed, and equipped to deliver mental health and/or substance abuse services to the public. According to regulation they are required to meet recovery standards including:

- Mission statement of the organization identifies recovery vision as driving the system
- Organization includes people who receive services in all phases of service planning and evaluation
- Primary outcomes identified for each service provided by the organization include measures of recovery

- Leadership of the organization reinforces recovery vision and recovery standards
- Policies and procedures of the organization are compatible with recovery values
- Organization provides access to an array of services so that recovery plans may
- be effectively individualized
- Organization provides training to improve knowledge, attitudes and skills necessary for all staff to conduct recovery-oriented services.
- Organizations shall promote recovery and empowerment by recognizing the uniqueness of each person receiving services and supporting the individual's:
    1. Expressed desires
    2. Strengths
    3. Choices and self-determination
    4. Self-management of her/his illness
    5. Direction of her/his treatment plans and service

Organizations offer services that ensure the opportunity for each person receiving services to attain the following service outcomes:

- An understanding of their behavioral health issue and the recovery process
- A belief in their own recovery
- Improved self-esteem
- Physical well-being
- Supportive relationships with family and peers
- Adequate resources to sustain a good quality of life
- Optimal functioning
- A safe and comfortable living environment
- Self-management of symptoms
- Knowledge of community resources and benefits/entitlements
- Engagement in daily activity that is meaningful to the person, e.g., employment;
- educational options; hobbies; initiatives of personal interest; supportive, structured activities etc.

Behavioral health services in RI are provided in specified geographic areas through Community Behavioral Health Organizations (CBHOs) designated by the Director of the Department. There are six CBHOs in RI serving eight catchment areas. Unlike some states, RI's behavioral healthcare system does not operate within a county structure. BHDDH contracts with seven (7) provider agencies, six of which are known as Comprehensive Community Behavioral Health Organizations (CBHOs) [formerly referred to as community mental health centers (CMHC's)], and one of which is a Specialized Service Agency (SSA). Each of the State's eight geographical catchment areas has a CBHO that assumes statutory responsibility for assuring that a comprehensive range of services are available for adults with severe and persistent mental illness. A total of 42,689 persons with behavioral health needs were served in FY 2014 in Rhode Island's community behavioral health system. 35,414 individuals over the age of 18 received mental health services (n=23,933) or substance abuse services (n=14,447); and 7,272 individuals under the age of 18 received mental health services (n=7,059) or substance abuse services (n=343). Each CBHO provides the following services:

- Wellness Promotion which includes a) consultation to other health, mental health, law enforcement and human service providers to assist them to recognize and address behavioral health problems

among their clients, and b) community education regarding the nature of mental illness and development of a positive attitude toward its prevention and treatment.
- Emergency Service is an immediate response by mental health professionals 24 hours per day, 7 days per week, to anyone experiencing a psychiatric emergency.
- General Outpatient Services (GOP). GOP services offers a range of diagnostic, clinical, and educational services that may vary in intensity level for persons suffering from behavioral health issues that adversely affect their level of functioning, but not severe or long-lasting enough to be disabling (usually less than 6 months).
- Community Support Service (CSP, Community Support Program) is the provision of care to individuals for persons with "Severe and Persistently Mental Illness (SPMI). All CSP-eligible clients have access to an array of intense, community-based treatment, rehabilitation and support services.

In addition to the services, the CBHOs are required to provide Health Home services to the SPMI and SMI Medicaid populations. All of the CBHOs are enrolled in CurrentCare, the State's Health Information Exchange.

The Rhode Island Integrated Health Homes (IHH) and Assertive Community Treatment (ACT) are the fixed point of responsibility to coordinate and ensure the delivery of person-centered care; provide timely discharge follow up; and improve client health outcomes by addressing primary medical, specialist and behavioral healthcare through direct provision or contractual or collaborative arrangement with the appropriate service providers of comprehensive, integrated services.

Individuals eligible for IHH services meet diagnostic and functional criteria and are assessed through the DLA tool completed at admission, every 6 months thereafter, or after significant change in clinical presentation. BHDDH has created an exception process for individuals who do not meet diagnostic criteria but require IHH services; e.g., individuals experiencing chronic homelessness who are cycling through emergency departments and institutions).

Assertive Community Treatment (ACT): is a mental health program made up of a multidisciplinary staff including a program director, registered nurse, masters level clinician, vocational specialist, substance use disorder specialist, employment specialists, peer specialists, and a psychiatrist. The ACT team provides support services in the community through relationship building; individualized assessment and planning; and active involvement with the client to find and live in their own residence, obtain and maintain employment, manage symptoms while involving natural and community supports as part of their care, to achieve individual goals, maintain optimism and recover. The team functions as a vehicle to provide whatever service or practical need a person requires to gain the skills and confidence needed to move towards greater degrees of independence. Services include: service coordination/case management; crisis assessment and intervention; symptom assessment and management; medication prescription, administration, monitoring and documentation; dual diagnosis for substance use disorder services; work related services; activities of daily living; social/interpersonal relationships and leisure time skills training; peer services; support services; education, support and consultation to clients' families and other support systems.

Integrated Health Home (IHH): is built on the person-centered medical home model that enhances the coordination of medical and behavioral healthcare. IHH provides linkages to community and social supports. The IHH team is made up of a master's level program director, registered nurses, hospital liaison, employment specialists, peer specialist and a medical assistant. The team's goal is to work within the client's plan to ensure the person's stability in the community through the coordination of care, mental health promotion and peer/family support. Services include care coordination and health promotion;

chronic condition management; comprehensive transition care; and individual and family support services.

IHH integrates the following practice: Psychopharmacological Treatment, Integrated Dual Diagnosis Treatment, Individual Placement and Supports, Family Psychoeducation, Clubhouse, Clinician Services-Disorder Specific Services, Crisis Assessment and Intervention Services, Supportive Employment and Education Services, and Psychiatric Rehabilitation.

General Outpatient treatment programs provide an array of services (biopsychosocial assessment, psychotherapy, counseling, psychiatric evaluation, medication treatment and review, psychological assessment, psychoeducation, 24-hour crisis services) that typically include group and family counseling and education. These programs offer comprehensive and coordinated diagnostic, clinical and educational services that may vary in intensity level per the needs of the person. The programs are encouraged to use EBPs to include treatment and recovery supports for persons with co-occurring mental health and substance use disorders.

Intensive Outpatient Services are interventions of greater frequency and intensity than general outpatient and community support services and are offered to an individual at risk of relapse or escalation of their illness.

Community Support Program provides comprehensive services for individuals in need of intensive and long term services to attain recovery. Services available include biopsychosocial assessment, individual, family and group counseling and psychotherapy, case management/CPST, psychiatric evaluation and medication prescription, education and management, integrated co-occurring treatment, ACT or intensive outpatient services, family psychoeducational services, community integration services, supported housing, residential services, crisis intervention and stabilization and peer support.

Residential Programs:

Supported Housing Services assists individuals to obtain and maintain safe, decent, affordable housing in the community through the provision of supportive services that focus on housing retention; including overcoming barriers to tenancy relationships with neighbors and landlords, adherence to lease requirements and health and safety issues.

Residential Services operate 24 hours a day, 7 days a week providing services and supervision to individuals in community settings. Services include promoting recovery and empowering individuals to improve or restore overall functioning.

Mental Health Psychiatric Rehabilitative Residences are programs that provide care for individuals who require increased structure due to their chronic mental illness may meet the group home level of care. Individuals must have a severe and persistent mental illness and be unable to live in a less restrictive setting in the community.

Behavioral Health Acute Stabilization Units are hospital diversion and step-down programs for people experiencing a psychiatric or substance use related crisis. The services include assessment and observation, crisis intervention, and treatment for psychiatric, substance use or co-occurring disorders.

Substance Use Disorder Residential Programs include ASAM level residential facilities that are required to have written cooperative agreements with detox programs; transitional programs for individuals leaving the Department of Corrections; and certified Recovery Housing that meet the level 2 and 3 National Association for Recovery Residences (NARR) standards.

Treatment/Clinical Services for SMI clients

Crisis Intervention Services are short-term emergency mental health services, available 24 hours a day, 7 days a week. The services include evaluation and counseling; medical treatment, including prescribing and administering medication; and intervention at the site of the crisis. Services continue until the crisis is stabilized. The BHCO/CMHOs are required to provide crisis intervention and stabilization services for adults who reside in their designated service area even if they do not have a current relationship with that behavioral healthcare provider.

Supported Employment Services: include the provision of job seeking training skills, job development and job matching, job coaching, follow-along supports, benefits counseling, referrals to the Office of Rehabilitative Services, career counseling and training, referrals to other community employment resources, planning for transportation, supported education, planning for GED and post-secondary programs, researching and applying for financial aid, accessing disability services, and referrals to community agencies that support education.

Criterion 1: Statewide planning for SUD prevention, treatment and recovery for individuals, families and communities.

CPST-SA: these services are community-based and are designed to address IHH clients requiring interventions and treatment with co-occurring substance use disorders. The CBHO teams use substance use disorder specific interventions. Evidence-based practices, such as motivational interviewing is used to engage clients to provide support, treatment and referral assistance. The CBHOs are not required to provide substance abuse treatment services, but all do provide substance abuse and co-occurring services within the continuum and have become significant providers of substance abuse treatment outpatient services within their local communities.

The Department realizes the need to increase the workforce's ability to address co-occurring disorders and is planning with the RI Substance Use and Mental Health Leadership Council, the Department's training and technical assistance provider, to assist CBHOs in achieving this capacity.

BHDDH has developed a continuum of specialized substance abuse services for adults in need of treatment for alcohol and drug dependence and abuse with multiple entry points through the licensing of behavioral health organizations (BHO) that provide detox, residential treatment, and medication-assisted treatment. The continuum includes, detoxification services, outpatient services and residential treatment) and recovery services (e.g., peer recovery specialists, recovery housing and recovery centers.

The Department's commitment to integrating behavioral healthcare with physical healthcare leads BHDDH to pursue this integration in both the mental health arena and the substance use disorder arena. For example, BHDDH implemented the nation's first opioid treatment program health home, as described below.

BHDDH functions as the state Opioid Treatment Authority. The Clinical Administrator reviews and monitors all exception requests and interviews consuming regarding treatment and recovery supports. Opioid Treatment Programs are required to incorporate evidence based practices based on the SAMHSA TIP 43.

Opioid Treatment Programs (OTP) Health Home (HH) initiative is a state-wide collaborative model designed to decrease stigma and discrimination; monitor chronic conditions; enhance coordination of physical care and treatment for opioid dependence; and promote wellness, self-care, and recovery through preventive and educational services. It is the fixed point of responsibility in the provision of person centered care; providing timely post-discharge follow-up, and improving consumer health outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers of comprehensive, integrated services. Emphasis is placed on the monitoring of chronic conditions, and preventative and education services focused on self-care, wellness and recovery. This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits.

The OTP Health Home team staff composition consists of a Master's Level Team Coordinator, Physician, Registered Nurse, case manager, Hospital/Healthcare Liaison, Case Manager, and Pharmacist.

The services are available for Opioid-Dependent Medicaid recipients who are currently receiving or who meet criteria for Medication-Assisted Treatment and are at risk of another chronic condition.

The OTP-HH tracks all federal and state required outcomes.

For patients receiving OTP Health Home services, the State tracks hospital referrals and/or hospital liaison encounters as well as face-to-face follow-up by a health team member within 2 days after hospitalization discharge. The State also monitors the number of referrals/post discharge follow-up contacts that resulted in development of a plan of care. The Department of Health (DOH) monitors and reports the number of referrals made to the Chronic Conditions Self-Management Education Programs and follow-through rates on those referrals. Claims data provides the state with information on the utilization of specialty care providers for chronic disease, frequency of appropriate screening, and potential medication adherence. This information is gathered by the Administrative Level Coordinator and submitted to BHDDH on a quarterly basis.

Each Health Home patient will have an established medical home and access to the DOH's Chronic Conditions Self-Management Education programs; as well as access to the Health Home team staff, all of which are documented in the Plan of Care to ensure coordination and follow up among team members and with the patient. Rhode Island uses claims, encounters, and clinical registry data to collect information on patients' coordination of care, including post-inpatient discharge continuation of care. The State monitors updates to RI-BHOLD to track changes in primary diagnoses, Axis IV diagnoses (e.g., housing problems, problems with access to health care services) and tracks individuals' self-reported co-occurring physical health conditions.

Centers of Excellence

The Center of Excellence is an innovative program in RI's fight to reduce opioid overdose deaths. It is a strategy which provides comprehensive evaluation, treatment (induction and stabilization services) and

referral for patients who need specialized outpatient treatment of opioid use disorders. These Centers will greatly increase timely access to care for individuals who present with an opioid use disorder diagnosis through "any door" in the health care system.

Centers of Excellence offer MAT in an outpatient setting; ***offering increased and immediate access for individuals who are ready and in need of immediate, intensive service that includes medication assistance.*** The Centers will work to stabilize patients and return them to an outpatient treatment or a primary care setting. The idea is to avoid or only use more intensive settings such as hospitalization and residential care when necessary.

The Department has created certification standards for the COEs and has approved four: CODAC Behavioral Health Care, an existing Opioid Treatment Program (OTP) which has six geographical locations throughout the state; Eleanor Slater Hospital; Care New England Hospital; and Community Care Alliance (a CBHO).

Any properly-licensed, operating health care facility, and approved Medicaid provider in good standing may apply to become certified as a Center of Excellence in the treatment of opioid use disorders. These Centers will provide assessments and treatment for opioid dependence, will offer expedited access to care and serve as a resource for community-based providers.

A multi-disciplinary staff, including peer professionals, will work together to provide patient-centered care that addresses all an individual's treatment needs. COEs will be able to provide medication services on-site, including all FDA-approved medications for the effective treatment of opioid use disorders (methadone, buprenorphine products and naltrexone). Recognizing that MAT alone is not sufficient to effectively treat OUD, the Centers also provide other necessary psychosocial interventions including peer recovery supports to assist people with their recovery from OUD.

Substance Use Disorder Services for Youth and Young Adults

BHDDH is the Single State Authority for program and policy development and implementation for adolescents. The adolescent treatment system has been in flux due to the changes in the landscape of RI's Medicaid system, the carve-in of behavioral health into managed care, the affiliation of smaller treatment agencies with larger behavioral healthcare organizations and marijuana possession legislation. Thus, the Department applied for and received a State Youth Treatment Planning grant to review the current system for youth and young adults ages 12-25 who have substance use disorders or co-occurring substance use and serious emotional disorders; identify need and gaps in the system and develop plans to address the needs. The plans include services, funding and workforce development. The grant is ending September 30, 2017 and BHDDH has received an implementation grant to address the finding of the planning grant.

The goal of the implementation grant is to create community based treatment programs for youth and young adults that are evidence based practices. Rhode Island will implement Seven Challenges in 4-6 sites across the state.

The current system includes:

- Outpatient programs that are operated by hospitals and licensed behavioral healthcare organizations. The programs range in size

- Intensive Outpatient programs operated by a hospital based organization and a licensed behavioral healthcare organization.
- Short term residential programs that are hospital based.
- Private Clinicians

The programs described above include psychiatric services, medication assisted treatment and other support services. The goal of the State Youth Treatment Implementation grant is to develop youth centric programs that addresses the continuum of service needs in an age appropriate manner that focus on recovery supports such as employment, education and housing, as well as treatment.

Peer Recovery Supports BHDDH also funds a variety of consumer-operated services that provide alternative support for the person to engage in the process of self-discovery and recovery. These activities include supported employment and recovery centers. Rhode Island contracts with the RI Parent Support Network to provide and coordinate peer support services across the State; to conduct education, training, supervision and evaluation; to research and develop a plan to subcontract with behavioral health organizations; and to facilitate a statewide Certified Peer Recovery Specialist(CPRS) Consumer Advisory Board, which is made up of 51% individuals in recovery from mental health or substance use challenges. PSN is working with partners across the State through a leadership forum to address issues and concern in the development and maintenance of the PRS program. Issues addressed include: increasing the numbers of CPRSs on community mental health center's Health Home teams; updating the CPRS curriculum; replicating local best practices such as the Alive Peer Social Community Inclusion Program; working with the federal technical assistance providers to develop standards for supervision; developing standard outcome measures; and identifying sustainable payment models. The program is focusing on providing peer recovery services in special populations including individuals who are homeless, involved with the criminal justice system including the re-entry population, young adults, culturally diverse populations, older adults, individuals who have experienced trauma, women in recovery and those who are pregnant, individuals on medication assisted treatment, and parents in recovery with children.

Priority Populations

Criterion 1: Comprehensive Community –Based Mental Health Service System: organized system of care for people with mental illness, including co-occurring Mental Illness/Substance Use Disorder that allow individuals to live in the community, outside of inpatient or residential institutions.

Criterion 2: Mental Health System Epidemiology: contains an estimate of the incidence and prevalence of SMI among adults and SED among children and have quantitative target to implement a system of care.

Criterion 3: Children's' Services

Criterion 4: Targeted Services to Rural and Homeless populations and older adults: outreach and community based services.

The Rhode Island Continuum of Care assists individuals and families experiencing homelessness or those at-risk of homelessness, and provides the housing and support services needed to rapidly and permanently end their homelessness and maintain stable housing. The Continuum of Care program promotes

community-wide planning and strategic use of resources to: address homelessness; improve coordination and integration with mainstream resources and other programs targeted to people at risk of or experiencing homelessness; and improve data collection and performance measurement that allows each community to tailor its program to it strengths and challenges. Representatives of relevant organizations within a geographic area establish a Continuum of Care to carry out the responsibilities set forth in the US Department of Housing and Urban Development (HUD) Continuum of Care Program Interim Rule.

In 2009 the HEARTH Act (Homeless Emergency Assistance and Rapid Transition to Housing) was passed by Congress and substantially changed homeless assistance policy. The HEARTH Act required, among other things, the development of a Continuum of Care governance structure to achieve substantive outcomes.

Rhode Island has a single Continuum of Care (RICoC) which guides the state's homelessness programs and policies, as well as administers federal and state homeless funds. The continuum includes a broad range of state agencies, community partners, and individuals who have experienced homelessness all working together to build a statewide system to prevent and end homelessness.

The U.S. Department of Housing and Urban Development (HUD) established the Continuum of Care (CoC) Program to:

- Promote a community-wide commitment to the goal of ending homelessness
- Provide funding for efforts to quickly re-house individuals and families who are homeless, which minimizes the trauma and dislocation caused by homelessness
- Promote access to and effective use of mainstream programs
- Optimize self-sufficiency among individuals and families experiencing homelessness

The RICoC promotes the HUD goals through a Coordinated Intake and Assessment process, utilizing a Housing First Model.

The RICoC consists of a Board of Directors, a membership group, and 6 standing committees (System Performance & Planning, Recipient Approval & Evaluation, Veterans, Families & Youth, Chronically Homeless/High Needs Individuals and HMIS)

In accordance with HUD regulations (24 CFR Part 578), representatives from relevant organizations that serve homeless and formerly homeless individuals and other interested, relevant organizations within the State of Rhode Island have established a Continuum of Care to carry out the duties assigned in the regulations.

The RICoC is a united coalition of community and state systems that assist homeless and near homeless residents in the State of Rhode Island to obtain housing, economic stability, and an enhanced quality of life through comprehensive services. RICoC addresses critical issues related to homelessness through a coordinated community-based process of identifying and addressing needs utilizing not only HUD dollars, but also mainstream resources and other sources of funding.

BHDDH applied for and received a Cooperative Agreement to Benefit Homeless Individuals in 2015 with a goal of housing 150 individuals experiencing chronic homelessness and providing supportive services, including supportive employment and recovery services.

Older Adults: Rhode Island has an Elder Mental Health Advocacy Coalition (RIEMHAC) that meets monthly at a programmatic level and policy level to identify needs in the community and gaps in services. The programmatic work group is made up of representatives from community based organizations including housing, mental health centers, and community organizations that serve the elderly population, as well, as advocates and state agencies. In services are provided to discuss promising programs and coordinate service delivery. A separate work group was formed in 2016 to address high level policy decisions. This is a sub-group of the larger programmatic work group and includes the addition of the Associate Director of Clinical Services and the Administrator of Quality Assurance at BHDDH, the Administrator for Behavioral Health services at Medicaid.

RIEMHAC is working closely with Rhode Island College to determine the statewide needs of this group.

Criterion 5: Management Systems: describe the financial resources, staffing and training for mental health service providers, emergency health services

The Department funds a percentage of staff from policy and planning, fiscal and data to plan and implement the Block Grant. The fiscal unit is made up of a Fiscal Administrator and three staff, one of whom is an accountant and the other two process contracts, purchase orders and process payments for the over _____ contracts supported through the Block Grant. The Policy and Planning unit is made up of three staff; an Associate Director and 2 associate administrators who ensure state and federal priorities are consistent through strategic planning, performance and adherence to the national outcome measures; and work at the interagency level to ensure that policies and practices are being created to leverage funding with a goal of sustainable for programs whenever possible. The Data unit has 2 staff responsible for data collection, uploading to the federal system and assisting the Block Grant team in implementing data based decisions.

All licensed agencies responsible for implementing the Block Grant programs receive training and technical assistance through a contract with the Substance Use and Mental Health Leadership Council, the trade association for behavioral health organizations (BHO). Trainings focus on workforce development at all levels of the organizations, the implementation of evidence based practices and technical assistance as requested directly from the BHO.

The prevention system all receives extensive training and technical assistance through a contract with JSI. The regional and local prevention task forces receive training on steps of the strategic prevention framework, evidence based practices, data collections and reporting and other direct technical assistance from the communities.

The State Innovations Model grant (SIM), a separate initiative through the Center for Medicaid Services administered through the Executive Office of Health and Human Services (EOHHS), will also be providing technical assistance and mentoring to the community mental health organizations (CMHO) late 2017 and throughout 2018 to assist in the implementation and fidelity to evidence based practices. This grant is focusing on the integration of health and behavioral health care.

10% Mental Health Set Aside: The Block Grant set aside is being used to support an additional 10 FEP individuals through the two Healthy Transition pilot sites at Community Care Alliance and the Kent Center. The Rhode Island Healthy Transitions model covers youth and young adults 16-25 years old who have or are at risk of having a serious mental illness or first episode psychosis. The programs utilize the evidenced-based practice Coordinated Specialty Care.

SAPT Criterion

Criterion 1: Statewide planning for SUD prevention, treatment and recovery for individuals, families and communities. See above

Criterion 2: Primary Prevention set aside See above

Criterion 3: Pregnant women and women with dependent children

The Department requires all agencies to develop policies to publicize services available to and prioritized for pregnant women. This is integrated into contracts, trainings and the Department's website. Targeted information is made available at the Human and Human Service Departments under the EOHHS umbrella, including, WIC Nutrition, Home Visiting, and Community Action programs; as well as, health centers and hospitals. All agencies are reviewed at licensing visits on their ability to implement such policies.

Below are Rhode Island initiatives that focus specifically on pregnant women with substance use disorders:

Neo-natal Abstinence Syndrome (NAS) Task Force is facilitated by the RI Department of Health (DOH). The NAS Task Force has developed guidelines for maternal and neonatal management of substance exposure, neonatal withdrawal and other drug effects. The Task Force has developed a two-year plan with work groups that focuses on 1) peer supports for pregnant and parenting recoverees 2) prenatal referral and linkage to care (substance use treatment, prenatal care, family support programs) 3) Hospital protocols for supporting substance exposed pregnancies at delivery. There is also a cross cutting focus area on provider education, as well as, a work group that focuses on DCYF protocol and training regarding substance use disorder. Some of the innovative programs that have been established through the NAS Task Force include: piloting peer recovery coaches to work with pregnant and parenting recoverees; piloting post-natal services to MAT patients; providing education and supports to families when they have babies with NAS; and improving quality of care for children with NAS through discharge and other hospital policy.

Project Dove provides clinicians with information and tools to help patients on opioid therapy understand its implications for pregnancy, identify a response to prescription opioid misuse among pregnant patients, and provide carte for pregnant women with opioid use disorder.

Recognizing the unique needs of women with mental health and addictions needs, the Providence Center, a community mental health center, provides services to women and their children. **Women's Day** is an outpatient program that allows women to address addiction issues and work towards recovery while remaining at home to take care of their family. **Project Link** is an outpatient program that works with pregnant women and their children on health and recovery issues. It offers intensive and non-intensive mental health treatment focusing on the mental health and addiction issues have on the pregnancy and post-partum period. The programs include babysitting services for clients with children.

Starbirth and Residential Treatment: the state residential programs have the capacity to provide services to pregnant women and prioritize this population. The programs also provide outpatient and intensive outpatient services. Starbirth is a specialized program for pregnant and post-partum women with their children. The program includes parenting programs, linkages to vocational services, prenatal services and works closely with child welfare services.

The state has a comprehensive **Domestic Violence service system** that provides shelter, transitional housing and permanent supportive housing to women and their children. The system focusing primarily on physical and sexual violence, however, all agencies work closely with the treatment system to make referrals to address the mental health addiction needs of their clients.

Criterion 4: **Persons Who Inject Drugs** (PWID) Licensed behavioral health organizations are required to provide access to treatment within 14-120 days of the request for services. All agencies most contract BHDDH within 7 days of reaching 90% of its treatment capacity. The program must admit each person who requests services and needs treatment for intravenous drug misuse no later than 14 days after making the request or within 120 days of the request if the program has no capacity to admit the individual, the program must make interim services available within 48 hours, and the program must offer the interim services until the individual is admitted to a substance abuse treatment program. The Department monitors the waiting lists to ensure access to services and partners with the DOH to provide linkages to the Education, Needle exchange, Counseling, Outreach, Referral (ENCOR) program for HIV and other blood borne pathogens prevention and intervention for people who inject drugs.

The interim services should include, counseling and education about HIV and TB, the risks of needle sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur. Referral for HIV and TB treatment services, if necessary; counseling pregnant women on the effects of alcohol and other drug use on the fetus of prenatal care for pregnant women. Each program has an established waiting list that includes a unique patient identifier for each person who injects drugs seeking treatment, including patients receiving interim services while awaiting Admission. The program must have a mechanism that enables it to maintain contact with individuals awaiting admission; consults with the Stare's capacity management system to ensure that a waiting list clients are admitted or transferred to an appropriate treatment program within a reasonable geographic area at the earliest possible time.

Criterion 5: TB BHDDH requires an ongoing program of surveillance, assessment and, if required, treatment of TB for all individuals receiving treatment in opioid treatment programs (OTPs) based on the established risk factor represented by drug/alcohol use and injection drug use for TB infection.

The following protocol is in place in Rhode Island and is based on the CDC guidelines for assessment and treatment of TB:

1. All new patients to substance use disorder treatment programs are asking screening questions related to TB on admission. Positive responses in substance use disorder programs other than OTPs generally trigger referral to the individual's primary care provider or directly to RI's RISE clinic for follow-up services (as described below).
2. All new patients to OTPs must have a tuberculin skin test (TST) (injection of purified protein derivative (PPD) under the skin and read by a qualified provider (e.g.: clinic RN) at 48-72 hours). TSTs are required to be repeated on a yearly basis.

3. A positive TST triggers further assessment with chest radiograph and sputum culture as clinically indicated. Additional testing will also be obtained as clinically indicated.
4. Confirmed diagnoses of TB are referred to the RISE clinic at Miriam Hospital which specializes in the treatment of TB for ongoing medical care.

The RISE clinic provides TB consultation and treatment services under contract with the RI Department of Health. All treatment services for both latent and active TB for RI residents over the age of 15 are coordinated through the clinic. Treatment for individuals aged 15 and younger is coordinated through an affiliated clinic at Hasbro Children's Hospital. The RISE clinic has approximately 8,500 patient visits annually. Services include outreach workers who meet with individuals who have been diagnosed with TB, escort them to the clinic, and provide an orientation to the treatment program immediately following hospital discharge. In addition, the clinic also offers a "directly observed therapy program." In this program, the outreach worker directly administers each medication dose to ensure compliance with treatment protocols.

Rhode Island had only 12 confirmed cases of active TB in 2016 (down from 40 cases in 2015) and these cases were reported as occurring in recent immigrants or patients residing in long-term care facilities. No cases of active TB were reported for individuals being treated for substance use disorders. For 2016, RI's licensed OTP providers reported that 17 patients were referred to the RISE clinic for follow-up.

Criterion 6: HIV/AIDS: All BHO are required to screen for HIV/Aids and refer to treatment. BHDDH and the EOHHS Ryan White program collaborated in 2017 to expand HIV screening and services to individuals who part of the behavioral healthcare system. The goal is to increase services to individuals who may be unaware of living with HIV and increase services. The grant will be providing an infectious disease physician to work in Centers of Excellence and OPT-Health Homes; providing funding for screening, including HIV training and education for peer recovery centers, peer recovery specialists and dedicate residential beds for individuals living with HIV/Aids.

Criterion 7: **Group Homes for Persons in Recovery from Substance Use Disorder:** The Revolving Loan Fund for recovery residences was a program offered through Block Grant funds through 2015. BHDDH subcontracted this program, to a community based agency to provide loans to increase recovery housing. The Department, working with our SAMHSA Block Grant officer, decided it would be appropriate to end the program since the state had increased the capacity for recovery housing and the loan fund was no longer necessary.

Criterion 8: **Referrals to Treatment:**
The Department requires standard screening, assessment and placement criteria to improve patient outcomes. All licensed behavioral healthcare organization (BHO) are required through regulations and contracts to provide screening, assessment and to develop person-centered treatment plans that address individualize services.

Below are the requirements in place for priority populations:

Pregnant Women

1. The program must refer pregnant women to the State when the program has insufficient capacity to provide services to any pregnant women who seeks the services of the program.

2. The program makes interim services available within 48 hours to pregnant women who cannot be admitted because of lack of capacity.
3. The program gives preference in admission to pregnant women who seek or are referred for and would benefit from treatment services.
4. If the program is a Substance Abuse Prevention and Treatment Block Grant funded program that serves persons who inject drugs, the program must give preference to treatment in the following order:
    i. Pregnant injecting drug users
    ii. Other pregnant substance use disorders
    iii. Other injecting drug users
    iv. All others
5. The program must refer pregnant women to the State when the program has insufficient capacity to provide services to any pregnant women who seeks the services of the program.
6. The program makes interim services available within 48 hours to pregnant women who cannot be admitted because of lack of capacity.
7. When appropriate, the program offers interim services that include, at a minimum, the following:
    a. Counseling and education about HIV and TB, the risks of needle sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur.
    b. Referral for HIV or TB testing, treatment and services.
    c. Counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women.
8. Program must make continuing education available in substance use disorder treatment and prevention services to employee who provide services.
9. The program must have a system in place to protect patient records from inappropriate disclosure and the systems complies with all applicable state and federal laws and regulations including 42 CFR, part 2. And include provisions for employee education on confidentiality requirements and the fact that disciplinary action may occur upon inappropriate disclosure.

Persons Who Inject Drugs

1. Within 7 days of reaching 90% of its treatment capacity, the program notifies the State whenever it reaches 90% of its treatment capacity.
2. The program admits everyone who requests and needs treatment for intravenous drug abuse:
    a. A. Not later than 14 days after making the request or
    b. Within 120 days of the request if the program has no capacity to admit the individual, the program makes interim services available within 48 hours, and the program offers the interim services until the individual is admitted to a substance abuse treatment program.
3. When appropriate, the program offers interim services that include, at a minimum, the following:

a. A. Counseling and education about HIV and TB, the risks of needle sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occurs.
b. Referral for HIV and TB treatment services, if necessary
c. Counseling pregnant women on the effects of alcohol and other drug use on the fetus of prenatal care for pregnant women,

4. The program established a waiting list that includes a unique patient identifier for each injecting drug abuser seeking treatment, including patients receiving interim services while awaiting Admission.
5. The program has a mechanism that enables it to maintain contact with individuals awaiting admission; consults with the Stare's capacity management system to ensure that a waiting list clients are admitted or transferred to an appropriate treatment program within a reasonable geographic area at the earliest possible time.
6. The program takes clients awaiting treatment for IDA off the waiting list only when such as cannot be located for admission into treatment or refuse treatment.

7. The program carries out activities to encourage individuals in need of treatment services for IDA to undergo such treatment by using scientifically sound outreach program ensures that outreach efforts.

HIV/early intervention programs, the program makes the following services available at the sites at which individuals are undergoing treatment for substance use disorder.

a. Appropriate HIV/AIDS pre-and-posttest counseling
b. Appropriate HIV/AIDS tests to diagnose the extent of the deficiency in the immune system and to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease.
c. Therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease,
d. The program also has established linkages with a comprehensive community resource network of related health and social services organizations to ensure a wide-based knowledge of the availability of these services and to facilitate referral.
e. Ensures that HIV early intervention services are undertaken voluntarily, provided with patient's informed consent, and are not required as a condition of receiving substance abuse treatment or any other services.

Pregnant women, women with dependent children and their children either directly or through linkages with community based organizations, a comprehensive range of services that includes the following:

i. Case management to assist in establishing eligibility for public assistance programs provided by Federal, State, or local governments
ii. Employment and training programs
iii. Education and special education programs
iv. Drug free housing for women and children
v. Prenatal care and other health care services
vi. Therapeutic day care for children

vii. Head Start
viii. Other early childhood programs

As described in Step 1, BHDDH applied for and received a Screening, Brief Intervention and Referral to Treatment (SBIRT). This grant will screen for behavioral health in primary care settings in 6 identified high need communities and the Department of Corrections.

Criterion 9: **Independent Peer Review (IPRC):** The Department contracts with RICARES to facilitate a peer review process. IPRC members include Program Directors and experienced clinical supervisors from licensed behavioral health organizations. All peer reviewers have demonstrated experience and expertise in the field of Substance Use Disorder treatment, and are experienced in a range of treatment modalities. The IPRC reviews clinical records, quality improvement and systemic concerns.

Criterion 10: Professional Development: The Department contracts with the Substance Use and Mental Health Leadership Council (SUMHLC), the trade association for the mental health and substance use disorder treatment providers to provide training and technical assistance to the Behavioral Health Organizations (BHO) on an ongoing basis. Trainings include certification for clinical supervisors, sexual abuse seminar, working with the LGBTQ community, addiction in the opioid crisis, for nurses, increasing knowledge on Hep C, gambling, MAT, illness management and recovery, functions of the substance abuse counselor, boundary in issues and dual relationships in substance abuse treatment, childhood trauma, opioid addiction pharmacology, care coordination, cultural elements in treating the Hispanic and Latino populations, anger management, ASAM patient placement criteria to determine appropriate level of care, motivational incentives and engaging the client, chronic illness, ethical and liability issues, pregnancy and addiction, understanding and applying 42 CFR Part 2, HIPAA and relevant confidentiality statutes, navigating the RI Court System, utilizing CBT in treat substance use disorder. Other trainings offered to the BHO by other organizations include evidence based practices for addressing homelessness, addressing mental health and substance misuse in the elder population

Rhode Island Prevention Resource Center (RIPRC) - The RIPRC is a centralized training and technical assistance (TTA) resource for Rhode Island substance abuse prevention providers designed to develop, expand and improve the prevention workforce. The RIPRC fosters state and local collaboration to prevent substance abuse and other risk-taking behaviors in Rhode Island. The RIPRC has been a key success for Rhode Island. Communities that utilized more TTA resources produced a greater number of successful policy changes in municipal and school policies relating to underage drinking. In 2011 BHDDH developed and funded the Rhode Island Prevention Resource Center (RIPRC) with Prevention Block Grant funds for 5 year.

Community Based Organizations (CBO): BHDDH works closely with community-based service providers that it does not license to ensure that individuals have choice in service providers. The CBOs include community action agencies, homeless services and supportive housing providers, agencies serving individuals with HIV/AIDS, family service agencies, federally qualified health centers, veterans' services providers, and domestic violence and women's services. Criterion 2: Primary Prevention set aside.

Primary prevention includes interventions, occurring prior to the initial onset of a substance use disorder, through the reduction or control of factors causing substance abuse, including the reduction of risk factors contributing to substance use. Services are delivered through six, defined, federal strategies listed below:

- Information dissemination-provides knowledge and awareness: e.g. health fairs, media campaigns, brochures, resource directories, Public Service Announcements;
- Education- two-way communication between educator/facilitator and participant: e.g. classroom, small group sessions, parenting/family classes, education programs for youth;
- Alternatives- provides constructive and healthy activities that exclude alcohol, tobacco, and other drug use: e.g. drug-free social and recreational activities, community drop-in centers, mentoring programs, community service activities;
- Environmental- establishes/changes community standards, codes, and attitudes: e.g. school drug policies, product pricing, social norms, technical assistance to maximize local enforcement;
- Community-based process- aims to enhance the community to more effectively provide substance abuse prevention services: e.g. systemic planning, community team-building, multi-agency coordination/collaboration, community and volunteer training, assessing service and funding.

The department's prevention system consists of four major components: regional task forces (coalitions), student assistance programs established by legislation; community-based programs, largely curricular in nature; and the Synar compliance program.

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Regional Prevention Task Forces were established in 1988 by State statute. Rhode Island has a statewide network of community-based substance abuse prevention coalitions, called Task Forces. The state's 32 Task Forces are primarily responsible for the development and implementation of comprehensive prevention plans for their respective communities, which are based on the results of a community needs assessment.

In 2016, the Department decided to revamp the prevention delivery system by creating regional prevention task forces. Historically, there had been 35 municipal level substance abuse prevention task forces charged with planning and coordinating comprehensive substance use prevention programming within each community. This regionalization, which was procured in 2017, is intended to achieve some economies of scale, reduce operating costs, streamline operations and improve outcomes on state-identified priorities using evidence-based and best practices covering five (5) of six (6) prevention strategies authorized by SAMHSA/Center for Substance Abuse Prevention in RI's cities and towns. The regionalization seeks to enhance the ability of local coalitions to implement evidence-based practices designed to engage communities and attain population-level changes in consumption patterns. The purpose is to provide regionalized coordination, which will increase the capacity of the local community task forces, while promoting efficiencies in process and improved outcomes. A secondary goal is to promote a lifespan approach, encourage collaboration across the continuum of care among multiple stakeholder groups concerned with behavioral health, and to leverage federal and private dollars to address local behavioral health priorities.

BHDDH utilizes a multi-year strategic planning process to set substance use prevention priorities throughout the State. The Regional Substance Abuse Prevention Coalitions (RSAPCs), are required to create a regional work plan which describes best practices and evidence-based practices that will be employed at the municipal level to address the priority problems identified in the State's substance abuse prevention strategic plan. The regional plan draws information from a set of municipal needs and resource assessments to create a set of regional priority needs. BHDDH, through a training and technical assistance contractor, provides support tools for assessment of community needs and resources. Each municipality

selects a set of evidence-informed or evidence-based practices that is congruent with the culture and context of their community.

This revitalized system for prevention is composed of regional prevention coalitions which 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 that retain their individual identity and continue to provide prevention services to their communities. The newly-developed regional prevention coalition provides administrative oversight, funding and other human, technical or financial resources needed to support municipal task force contributions to a regional prevention plan, and acts as the fiduciary and administrative agent.

The Regional Substance Abuse Prevention Coalitions (RSAPCs) are using funding for three priorities: (1) to increase the use of evidence-based policies, practices and programs by municipal substance abuse prevention coalitions across the lifespan, as well as among various sectors and community stakeholders (schools, law enforcement, prescribers of opioid medications) based on the findings of the municipal needs assessments;(2) to implement environmental change strategies to raise awareness of potential for harm, and reduce youth access to harmful legal products (e.g., products which might be legal for use by a segment of the population such as adults but which are not legal and are potentially harmful to others such as youth); and (3) to use media and communication strategies to promote positive behavioral health, increase the perception of risk or harm from substance use and correct normative misunderstandings of the norm among youth and young adults (e.g., everyone drinks alcohol).

Each Regional Prevention Coalition has set aside a percentage of their direct cost budget to manage a performance-based incentive fund for municipal members. In addition, each Regional Prevention Coalition is providing funding for incentives. One of the greatest challenges to the substance abuse prevention field in Rhode Island, as well as nationally, is the recruitment of new employees, and the retention of current ones, as our workforce ages into retirement or changes careers. BHDDH is dedicated to the recruitment, retention, education, and training of substance abuse treatment and prevention professionals and to improving the quality of our workforce. BHDDH has worked with the New England Addiction Technology Transfer Center (ATTC-NE), the New England Institute of Addiction Studies (NEIAS), the Rhode Island Prevention Resource Center (RIPRC), the Substance Use and Mental Health Leadership Council of RI, the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for the Application of Prevention Technologies (CAPT) our state colleges and universities, and other community partners to develop and implement new initiatives to support workforce development.

The Department is enhancing the community prevention task forces' ability to target opioid use disorder in high need communities through the State Treatment Response grant. The Regional Prevention Coalitions will implement Project Lazarus, a comprehensive community approach to reduce opioid overdose and prescription drug misuse. The Regional Prevention Coalitions will implement at least one activity from each of the following Lazarus components: Community Organization and Activation, Prescriber Education and Behavior, Supply Reduction and Diversion Control and Community Based Prevention Education as part of the primary prevention scope and focus of their work. In addition, an Opioid Prevention education strategy will be implemented in the high schools among the communities identified as high need (West Warwick, Cranston, Hopkinton, Providence, Charlestown, Johnston,

Pawtucket, Westerly, Warwick, Woonsocket, Central Falls and North Providence) in Rhode Island's STR application.

The **Strategic Prevention Framework Partnership for Success** initiative is focusing on twelve (12) Rhode Island communities for substance abuse prevention activities targeting underage drinking and youth marijuana use. These communities were identified as high need based on their youth prevalence rates and a set of social indicators related to negative consequences of substance abuse based on the 2013 State and Community Epidemiology profiles. (See below). Funding for the communities began July 1, 2014 and ends September 29, 2018.

PFS Communities by Priority Substance		
Underage Drinking	**Marijuana Use by Youth 12-17**	**Both**
Burrillville	Cumberland	Foster
Cranston	Lincoln	Johnston
Providence	Little Compton	Newport
Westerly	Scituate	New Shoreham

Major accomplishments for the PFS initiative in 2016 include: full implementation of evidence-based practices by most of the communities. Many of the evidence-based practices were delivered in school settings; therefore, during the summer of 2015 many sub-recipients received training on the EBPs and implemented many of them in fall or early winter of 2015. The sub-recipients implemented multiple strategies in different settings. Please see Table X on the next page for a summary of evidence-based practices implemented in federal fiscal year 2016 and 2017.

Major accomplishments for the PFS initiative in 2017 include the implementation of evidence-based practices continued into this year, with eleven out of twelve communities implementing evidence-based practices. Several communities have made modifications to their strategic plan to accommodate changing needs and capacity. Proactive technical assistance was provided around sustainability as a mandatory three-part series this year to prepare funded municipalities for the eventual completion of this grant. Anticipated state-mandated capacity building around applying for grants and funds acquisition will occur after October 2017 for similar reasons.

Rhode Island Student Assistance Services (RISAS) - The Rhode Island Junior High/Middle School Student Assistance Act (R.I. General Laws 16-21.3) was established by the Rhode Island General Assembly in 1989. The Statute authorized funding to establish student assistance programs (SAPs) in junior high and middle schools throughout the state. Student Assistance is based on the nationally recognized Westchester County student assistance program, which is similar to employee assistance programs (EAPs). SAPs focus on behavior and performance at school, using a process to screen students for alcohol, and other drug problems. The counselor provides early identification, comprehensive assessment, intervention and referral, if necessary, to adolescents who are experiencing high risk behaviors. The counselor also acts as a liaison between the school and school personnel, parents and a variety of community agencies. This model enables a school to more effectively and efficiently carry out its function of educating students. BHDDH's overarching goals: is to identify individuals ages 12-18 who

are exposed to risks or experiencing early symptoms that increase the potential that they will use or misuse alcohol and/or other substances. The Department has contracted with RI Student Assistance Services (RISAS) to provide school and community-based substance abuse prevention and early intervention services to Rhode Island schools and communities. RISAS is implementing Project SUCCESS, an evidence-based SAMHSA program, in over 40 Rhode Island middle and high schools.

Rhode Island Prevention Resource Center (RIPRC) - The RIPRC is a centralized training and technical assistance (TTA) resource for Rhode Island substance abuse prevention providers designed to develop, expand and improve the prevention workforce. The RIPRC fosters state and local collaboration to prevent substance abuse and other risk-taking behaviors in Rhode Island. The RIPRC has been a key success for Rhode Island. Communities that utilized more TTA resources produced a greater number of successful policy changes in municipal and school policies relating to underage drinking. In 2011 BHDDH developed and funded the Rhode Island Prevention Resource Center (RIPRC) for 5 years with Prevention Block Grant funds.

To effectively target TTA resources, the RIPRC collects baseline training and technical assistance needs and organizational capacity information every two years. In the spring of 2017, twenty-two (22) unique providers were given needs assessment surveys and a total of sixteen (16) providers completed the survey, a 73% completion rate.

It is essential that the RIPRC matches its trainings to the needs of the providers in the state. This targeted approach facilitates core competency development in the workforce, allowing providers to better serve their communities. As RI moved to a regional prevention service delivery model this year, the results of the needs assessments were related to the transition. The RIPRC needs assessment identified six (6) strategic training content areas to focus on to increase the capacity of communities to implement, sustain, and improve effective prevention initiatives. These content areas include:

- Sustainability Planning (60%)
- Recruitment and Retention of Coalition Members (60%)
- Prevention Certification Testing Preparations (40%)
- Improving Communication and Cohesion within Newly Established Regions (40%)
- Prevention Policy Development (40%)
- Navigating Political Systems (27%)

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.

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.

The new FDA contract includes a goal of engaging the newly-formed Regional Prevention Coalitions to partner with the FDA team to utilize FDA inspection results to recognize their tobacco retailers who continually comply with tobacco laws and provide staff training and education to those retailers who have had inspection violations.

BHDDH's FDA team will continue to work with state partners at the Department of Health to coordinate effective state tobacco education for retailers, legislators, youth and community partners to keep health and compliance issues related to tobacco a priority.

Discretionary and Formula Grants

BHDDH has taken advantage of federal discretionary grants to pilot evidence-based practices and innovative programs to increase access to and quality of services. The discretionary grant funding has allowed the Department to focus on populations that are traditionally underserved, pilot evidence-based practices and create a sustainable systemic approach to funding services. The Department has been awarded the following grants and cooperative agreements:

Programs for Assistance in Transition from Homelessness (PATH) funds outreach and direct services to individuals who are experiencing homelessness, as well as, statewide coordination of the outreach and education and training to community-based organizations who work with the population on evidence-based practices. Most individuals contacted by PATH outreach workers have serious mental illness and co-occurring substance use disorders. Outreach is concentrated in those areas of the State having the largest number of individuals experiencing homelessness. Current efforts are focused on the capitol City of Providence, East Providence, Pawtucket, East Greenwich, Warwick, West Warwick, West Greenwich, and, to a lesser extent, Washington County. The PATH service provider, in conjunction with other organizations conducting street outreach, is planning to expand outreach efforts in Newport County, the City of Woonsocket, and Washington County. During SFY 2016, 204 individuals were contacted by PATH outreach workers and 115 were enrolled in the program. Sixty-one received community mental health services and ten received treatment for substance use disorders. Over the next year, the PATH implementation team will develop and implement a plan to enhance outreach efforts by incorporating evidence-based practices, identifying different categories of outreach workers based on degree of complexity of service needs, and potentially to create a referral process whereby non-PATH outreach workers would refer individuals with SMI or SMI/SUD to PATH outreach case managers.

Healthy Transitions: Healthy Transitions RI is in the process of addressing the needs of 250 youth and young adults ages 16-25 with Serious Emotional Disturbance (SED), Severe Mental Illness (SMI) and/or Co-Occurring Disorders (COD) in two Rhode Island communities. Two cities, Warwick and Woonsocket, Rhode Island, built a local advisory structure to guide the local development of the project, make the communities aware of the needs of these young people, collaborate to help identify, engage and screen those at risk for developing SMI and/or co-occurring disorders and, through the cities' two Community Mental Health Organizations, provide specialized intensive services to those who are experiencing SMI/COD. These services will involve several evidence-based practices delivered within the Coordinated Specialty Care (CSC) model.

Partnership for Success (PFS) the Rhode Island Strategic Prevention Framework Partnerships for Success (PFS) project provides funds to twelve communities to address underage drinking efforts with youth ages 12-17 and reduce marijuana use among youth 12-17, as well as to assess prescription drug use and misuse among youth and young adults ages 12-25 and the resultant burden. The PFS currently provides funds to support the work of the State Epidemiology and Outcomes Workgroup and this group has collected and disseminated state level and community level data relevant to substance use and related consequences, including opioids.

Cooperative Agreement to Benefit Homeless Individuals (CABHI): This grant was awarded in the fall of 2015 to provide permanent supportive housing for individuals experiencing long term homelessness, veterans and individuals cycling through prison and the homeless system. The focus is on individuals experiencing chronic homelessness, veterans, and individuals cycling through the Department of Corrections and the homeless system. The program will provide supportive housing, treatment and recovery services to 150 individuals over a three-year period and provide additional treatment and recovery services to an additional 150 individuals who are currently residing in supportive housing.

State Youth Treatment Planning (SYTP): This planning grant was awarded in the fall of 2015 and the Department applied for and received an implementation grant to focus on substance use disorder treatment evidence-based practices for youth and young adults ages 12-25 with SUD or co-occurring substance use disorders and mental health issues. Planning has been taking place over the last 17 months with community providers and youth and young adults and the feedback will be a part of the planning process for the initiatives of this grant.

Medication Assisted Treatment (MAT): This grant was awarded in the fall of 2016 and is creating 6 Centers of Excellence over a three-year period to provide medication assisted treatment in collaboration with primary care settings.

Screening, Brief Intervention and Referral to Treatment (SBIRT): Rhode Island SBIRT will pre-screen 250,000 Rhode Islanders over a five-year period; approximately 30,000 in year 1 and 55,000 in years 2-5. The screening will cover tobacco, alcohol, marijuana and other drugs and be delivered to individuals in primary care and health centers, emergency departments, and the Department of Corrections. This initiative complements the State's efforts to integrate health and behavioral health care.

Ryan White: BHDDH is collaborating with EOHHS, the state agency administering the Ryan White funding, to incorporate HIV/AIDS education, awareness, screening and treatment into the behavioral health care system. The initiative will provide access to an infectious disease physician within the OTP Health Homes, allow for screening of individuals who may have been unaware of the disease, establish HIV/AIDS capacity within the peer recovery specialist programs and in the recovery centers, and permit priority access to residential beds.

State Treatment Response (STR): The RI State Targeted Response (STR) grant will address the strategies identified in our State's Overdose Prevention and Intervention Action Plan including increasing access to treatment, reducing unmet treatment needs and reducing overdose deaths through prevention, treatment and recovery support initiatives. The RI-STR will ensure that all federal, state and private funding is synchronized to move forward the state's action plan and is alleviating identified gaps in services.

State Youth 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.

Awaiting award announcement

Promoting the Integration of Health and Behavioral HealthCare (PIPHBHC): This program, if awarded, will focus on children and adolescents ages 0-17 who have serious emotional disturbances and chronic health conditions. The program will treat the child/adolescent holistically and therefore, provide services to family members, as defined by the child/adolescent.

Summary of General Strengths and Needs of the System

The Rhode Island Behavioral Healthcare system has a number of strengths, which include:

1. **The State is committed to comprehensive reform as described in the introduction. Through initiatives such as Re-inventing Medicaid and the State Innovations Model grant the departments under the Executive Office of Health and Human Services are collaborating in an unprecedented manner to address systemic issues including the integration health and behavioral health care, treatment services for youth and young adults and workforce development.**
2. **This collaboration is carrying over to other initiatives including the Opioid Overdose Task Force (a partnership between BHDDH and DOH), Healthy Transitions and the State Youth Treatment Planning/Implementation grants (partners BHDDH, DCYF and Medicaid) and the Medication Assisted Treatment program in prison (partnership with BHDDH and DOC).**
3. **BHDDH has reorganized its Division of Behavioral Healthcare to integrate mental health, substance use disorder and prevention across units.**
4. **The Department is leading the country in its certification of Peer Recovery Specialist and innovative use of peers in emergency departments and high need community "hot spots" to address the overdose crisis.**
5. **BHDDH has strengthened its capacity to apply for federal discretionary grants to pilot innovations in the field of MH, SUD and prevention.**
6. **The Department is in the process of revising its regulations with community stakeholders to ensure regulations, certification standards and policies and procedures are transparent and focus on person/family centered services, employ evidence based approaches, promote trauma informed services and are recovery oriented.**

1. **The behavioral healthcare system also has a number of needs which are addressed in Step 2, and include a robust data analysis capacity that can provide information on statewide needs and performance and service outcomes across departments.**
2. **A nimbler purchasing and contracting system that would enable the department to respond to and implement discretionary funding in an expedited manner.**
3. **Additional state and other funding to allow sustainability of promising programs being piloted and allow agencies to address fidelity of evidence based practices.**
4. **Collaboration across state departments on training, cultural competency, diversity and policies and procedures.**
5. **Lack of age appropriate services in MI/SUD for transition aged youth (14-26).**
6. **Expansion of screening for prevention and early intervention,**
7. **Behavioral Healthcare Workforce Development.**

Step 2 ***Unmet service needs and critical gaps, for the specified populations and the data used to identify these needs. How is the state addressing these needs. Community level data, NSDUH, TEDS,URS, BH Barameter, National Facilities Survey on Drugs and Alcohol, SEOW, NSSATS, CMS data and AHRQ, Healthy People's Initiative***

A number of behavioral health focused needs assessments conducted in the past year have helped to shape priority goals and objectives for the State's behavioral health plan. The combined input has been used to develop the statewide community needs assessment and funding priorities for this document. Each of these needs assessments focus on different constructs of behavioral health needs and together provide a robust picture of needs, resources and key stakeholders.

There were consistent themes across the needs assessments:

- Rhode Island (RI) experiences rates of use and negative consequences of substance abuse that exceed national and regional rates in a number of instances
- Hospitalization rates are higher than national and regional averages
- Crisis services are not adequate
- RI young adults are heavily impacted by behavioral health issues but few services are directed to them
- Promotion, prevention and early intervention are underutilized and under resourced
- There are numerous barriers to receiving proper evidence-based or evidence-informed community-based care including reimbursement rates

Related Strategic Plans and Reports

Several strategic plans or reports have been published in the past few years identifying strategies, interventions and evidence-based practices to address the specific behavioral health needs identified above:

State of Rhode Island Final Strategic Plan for Substance Abuse Prevention 2016-2019 (2016) [1]- Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

This plan outlines BHDDH's primary prevention goals and strategies to strengthen the infrastructure and to provide support at the State and community-level to prevent and reduce the use of alcohol, tobacco and other drugs among youth and young adults. The aim of this plan is to provide a roadmap to increase the capacity of the State's prevention workforce; to support key stakeholders, prevention providers and policy makers to understand, promote and work towards preventing and reducing substance use among youth and young people; and to create an integrated regional prevention service delivery system which incorporates a broader behavioral health approach.

The goals are to reduce four behavioral health consequences: DSM-V diagnoses of illicit drugs dependence or abuse; DSM-V diagnoses of alcohol dependence or abuse; drug overdose, especially those attributed to opioids and prescription drugs; and suicide attempts among adolescents. These reductions will be accomplished by attaining a 3-4% reduction in the following consumption patterns, as reported in Youth Risk Behavior Surveillance System and the RI Student Survey, which are linked to the consequences targeted: marijuana use by adolescents ages 12-17; use of illicit drugs other than marijuana ages 12-25; underage drinking ages 12-20; and youth use of tobacco or tobacco related products (specifically use of electronic nicotine delivery systems). As measured by the Youth Risk Behavior Surveillance System and the RI Student Survey, the network of Regional Prevention Coalitions will implement activities and evidence-based practices that are designed to obtain a 10% reduction by 2019 among the these risk factors which have been linked to the consumption patterns noted above: low perception of risk or harm of the targeted substance; and, easy access or perceived ease of access for priority substance among populations for whom possession, use or consumption is illegal (e.g., alcohol <21, marijuana without a medical marijuana card <18, use of prescription medication by someone other than to whom it is legally prescribed, and tobacco <18).

Rhode Island's Strategic Plan on Addiction and Overdose: Four Strategies to Alter the Course of an Epidemic - 2015[2]
Rhode Island Governor's Overdose Prevention and Intervention Task Force

The expert advisors for this Strategic Plan reviewed the existing literature on addiction and overdose; conducted over 50 interviews with local, national, and international stakeholders and experts; collected input from the Rhode Island community via a website, which hosted several surveys; hosted two public forums with expert and community panels; and presented progress to the Task Force as well as a draft plan for feedback and public discussion.

The strategic priorities contained in this plan are: 1) Establish statewide overdose surveillance mechanisms; 2) Increase access to naloxone training and distribution programs; 3) Implement and expand

[1] Final Strategic Plan for Substance Abuse Prevention 2016-2019. Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, 2015.
http://www.bhddh.ri.gov/substance_use/prevention.php

[2] Rhode Island's Strategic Plan on Addiction and Overdose: Four Strategies to Alter the Course of an Epidemic. Rhode Island Governor's Overdoes Prevention and Intervention Task Force, November 4, 2015.
http://preventoverdoseri.org/the-task-force/

disposal units throughout the state; 4-5) Increase public awareness of drug overdose as a preventable public health problem and support and affirm people who are at risk of overdose; and, 6) Increase access to substance use disorder treatment

The Strategic Plan identifies four key strategies and related activities designed to reduce overdose deaths by one-third within three years, using four key strategies: increase access to medication-assisted treatment; ensure a sustainable source of naloxone for community and first responder distribution, and a high coverage of naloxone among populations at risk of overdose; ensure prescribers use the Prescription Drug Monitoring Program (PDMP) and other system-level efforts to reduce co-prescription of benzodiazepines with opioids (for pain or opioid use disorder); and, large-scale expansion of recovery coach (peer recovery specialist) reach and capacity.

Rhode Island Behavioral Health Project: Final Report Truven Health Analytics - 2015[1]
RI Executive Office of Health and Human Services, Department of Health, Department of Behavioral Health, Developmental Disabilities, and Hospitals; and, Office of the Health Commissioner.

The Rhode Island Executive Office of Health and Human Services (EOHHS); the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH); Department of Health; and the Office of the Insurance Commissioner (OHIC) contracted with Truven Health Analytics to develop a series of reports that quantify statewide demand, spending, and supply for the full continuum of behavioral health services in the state. Subsequent to these analyses, Truven Health was asked to develop a summary report recommending practices, policies, and system structures to further the goal of providing accessible, high quality, and affordable care.

The following recommendations related to provision of behavioral health were issued in the final report:

- Rhode Island should place greater emphasis on investments in proven, effective, preventive services and supports for children and families.

- Rhode Island should shift financing and provision of services away from high-cost, intensive, and reactive services toward evidence-based services that facilitate patient-centered, community-based, recovery-oriented, coordinated care.

- Rhode Island should enhance its state and local infrastructure to promote a population-based approach to behavioral healthcare. Specifically, Rhode Island should: (1) routinely generate and disseminate behavioral healthcare need, supply, use and spending information across funding and organizational silos; (2) develop planning processes that involve and incentivize disparate organizational, financing, and delivery systems; and (3) create accountability measures that are tied to population-level outcomes.

Adults with SMI:

Rhode Island, at 24%, has the highest rate of mental health illness in adults in the country. Per the Truven Demand Study, Rhode Island has higher rates of serious psychological distress than the other New England states and the nation. Adults ages 25 to 64 receiving mental health care in the past year (24% in 2011) is much higher than both the other New England states and the country (15%). Finally, Rhode Island has a higher hospital admission rate for mental illness for adults than the other New England states and the nation. At the same time, more Rhode Island adults (7%) are likely to report unmet needs for behavioral health than are adults in the other New England states.

Unmet service needs: As noted above, the Truven Study indicates that Rhode Island is overly reliant on psychiatric hospitalization and prescription medications. This dependence on what it characterizes as "high-cost, intensive and reactive services" has unsatisfactory results for consumers and drives behavioral healthcare costs higher than in most other states. The $853 million spent on behavioral health treatment in 2013 represented 1.6% of its gross domestic product, as opposed to the national average of 1.2% of gdp.

The Truven report identifies the lack of investment in patient-centered, community-based, recovery-oriented, coordinated care using evidence-based services as the reason for the overuse of psychiatric hospital care. Among the problems cited:

- The end of Assertive Community Treatment in 2011
- The low rate of per capita spending on community services. Rhode Island rate 29th in the nation on this measure.
- The shortage of behavioral health and substance abuse counselors as compared to the other New England states.
- The lack of coordination between psychiatric hospital and community treatment. One in five Rhode Island Medicaid beneficiaries had no follow up mental health services following hospital discharge.
- The lack of affordable supportive housing services. Rhode Island's mental health system has a higher rate of homelessness among its clients than the national average (5% versus 3.3%), only 2.6% of those with SMI served by the system received supportive housing.
- The lack of integration between community services and Medicare, Medicaid (both fee-for-service and MCO) and private insurers. Some best practices in community-based services are not fully funded or not funded at all by insurers.

What the Department is currently doing to meet these needs: The Department manages a number of initiatives to address aspects of the need for more community treatment and recovery supports. These include:

- Integrated Health Home services that provide case and care management, peer supports, health and wellness service and employment supports in addition to psychiatric and counseling services
- The continuing expansion of peer supports and recovery services across the system (see "Recovery" Environmental Factor #17)
- The Coordinated Specialty Care EBP for first-episode of SMI in the Health Transitions
- The 811 program for permanent supportive housing and CABHI grant-funded housing retention services
- Outreach and engagement through the PATH grant
- Medicaid funded recovery supports through the Health Home teams.
- Block-grant funded training for CBHO staff
- SIM Mentoring Program for community mental health centers.

- The mental health court diversion program training
- Specialized residential peer supports

Plans to address unmet needs:

Rhode Island is in the process of transforming its behavioral healthcare system through several initiatives that are focusing on integrating health and behavioral healthcare systems and creating, through our reinventing Medicaid legislation, new service packages that would provide housing stabilization and recovery services through Medicaid. The state has submitted this request to CMS and is awaiting a response.

BHDDH has a three pronged approach to address the needs of individuals with SMI.

1. Peer Supports: The Block Grant is funding a comprehensive peer support system. BHDDH has made major advances with regard to Peer Recovery Services. Over the past eight years the development of peer services in Rhode Island, which included the initial training of substance abuse Recovery Coaches (2007), the firs training of Peer Specialists to support people with mental illness (2012), the certification of mental health peer specialists by BHDDH (2012), the Rhode Island Certification Board's development of a certification for Peer Recovery Specialists and the receipt of SAMHSA/BRSS TACS awards in 2014 and 2015. The current system includes certified Peer Recovery Specialist that specialize in mental health, substance use disorders, criminal justice involved, opioid use disorders and homelessness. The state is receiving technical assistance to develop standards for supervisors of peer recovery specialists.

Funding Peer Recovery Specialists
BHDDH is coordinating and strengthening the infrastructure and leadership for Peer Recovery Specialist as well as providing assistance in integrating PRS into existing community services and activities. This is being accomplished through:

- Providing and coordinating peer support services, education, and training through a contract with the Parent Support Network
- Developing and implementing prototypes for essential tools and systems to professionalize the field of Peer Recovery Specialists, including supervisor training
- Implementing a plan for hiring Peer Recovery Specialists and subcontracting their services to Behavioral Health Organizations
- Developing avenues for PRS to impact the Opioid Crisis and pregnant women with OUD.

2. **Supportive Housing Programs**: BHDDH recognizes that housing is a critical component in the lives of individuals with SMI. The goal of the Department is to provide housing opportunities in the least restrictive setting. The housing should be integrated into the community and affordable, meaning individuals pay no more than 30% of their income for rent. BHDDH has collaborated with the state's housing finance agency (HFA) on two grant programs. The first program is the Department of Housing and Urban Development's 811 program. This program will provide 150 subsidized housing units through the state's HFA for individuals who are experiencing chronic homelessness, BHDDH's population who would like to live in the community in supportive housing and individuals in the state's Money Follows the Person program. The state service departments (BHDDH and Medicaid) provide supportive services to ensure individuals can retain housing. The second grant is the Cooperative Agreement to Benefit Homeless Individuals. This program provides treatment and recovery services, including supported employment, and 150 new housing vouchers to individuals who are homeless and have mental health and substance use disorders. The program will also provide treatment and recovery support services to 150

individuals who are currently living in permanent supportive housing who have not traditionally had access to these services.

3. **Housing Stabilization Services**: BHDDH and other community based providers have been developing a Housing Stabilization Service package with the Division of Medicaid over the past several years. The request was submitted to CMS and the State is awaiting approval. This package of services would provide a continuum of services that focus on housing retention education and include care coordination, peer supports, daily living skills, case management, supportive employment and recovery services.

Older Adults with SMI

Needs and Service Gaps:

As with adults with SMI in general, Rhode Island's elderly adults tend to be hospitalized and put into other intensive residential treatment for lack of a more robust community services capacity. The Truven Study notes, Rhode Island adults over age 65 are admitted to mental health and substance abuse facilitates at a higher rate than the national average. Currently, roughly 80 percent of long-term care dollars are spent on elders and adults with disabilities in nursing homes, a third above the national average. BHDDH met with the Division of Elderly Affairs and EOHHS' "Money Follows the Person" team and held a focus group of the Rhode Island Coalition on Elder Mental Health and Addiction Coalition to explore this problem area. The gaps identified were:

- A lack of residential care that can accommodate individuals with SMI who do not require nursing home level of care
- A lack of home and community-based behavioral health care for individuals who are not CSP clients. This means that home-based specialized geriatric behavioral healthcare and case management are largely unavailable.
- A lack of geriatric expertise in most of the BHOs. State regulations do not require geriatric-specific services. Only one CMHO has staff specifically assigned to working with elders.
- The lack of capacity to deal with behavioral health issues among medical home health programs.
- A lack of continuity of care between hospital and community. There are wait times to get behavioral healthcare (which is usually office-based) post discharge and little case management to follow through on medication and other issues.
- Attitudes towards help-seeking, particularly around behavioral health, among elders.
- Under-recognized substance abuse problems among seniors.

What services are currently provided:

- The Division of Elderly Affairs contracts with CAPs to respond to emergency services for elders in their homes and follow up case management. This is a voluntary, non-emergency service. After hours, the state's 2-1-1 service provides phone response. In psychiatric emergencies, one of the CMHOs provides its in-person emergency response, which may be in the home.
- Home-based behavioral Health Home services are provided to the IHH's clients.
- MCOs can provide care management.
- BHDDH administers the state's PASSR program

- BHDDH staffs in the Rhode Island Coalition for Elder Mental Health and Addictions (RIEMHAC), which includes homeless service providers, direct service providers, community action programs, the Department of Elderly Affairs, homeless service providers and the Money Follows the Person initiative to identify gaps in the system and develop appropriate community based services.
- BHDDH collaborates with the EOHHS to improve access to care.

Plans to address the needs:

- Work with EOHHS Division of Medicaid to develop a housing stabilization service package that would be reimbursable through Medicaid.
- Work with EOHHS/Medicaid to ensure all MCOs to provide care management for elders.
- Adapt the Department's Peer Recovery Specialist initiative, which is funded through the Mental Health and Substance Abuse Prevention and Treatment Block Grants, to be a resource for older adults with SMI and SUD through specialized older adult peer recovery specialists.
- Adapt the Department's training contract to enhance awareness and clinical skills around geriatric issues.
- Begin planning policies and procedures with Medicaid that require enhanced CMHO capacity for geriatric practice.
- Work with RIEMHAC and EOHHS on strategies to enhance basic awareness of geriatric behavioral health issues among home health programs

Individuals with SMI or SED in the rural and homeless Populations

Homeless Adults w/Behavioral Disorders:

Per the National Alliance on Homelessness, 2014 State of Homelessness Report, in January 2014 the national count found 578,424 persons experiencing homelessness (18 persons experiencing homelessness of every 10,000 persons in the public). Persons experiencing chronic homelessness represent approximately 15% of the homeless population (84,291). Veterans represent 9% (49,933). Across the country in the last 5 years, the number of veterans experiencing homelessness was reduced by 33% and persons' experiencing chronic homeless was reduced by 30%. In Rhode Island, the January 2014 Point in Time Count found 204 chronic homeless persons and an additional 108 homeless veterans.[3]

The Rhode Island Coalition for the Homeless administers the state's Homeless Management Information System (HMIS) and reported an 8.5% decrease in the overall numbers of homelessness from 4,447 to 4,067 in 2014. The decrease in overall homeless numbers can be attributed to a couple factors; 1) targeting available units for veterans and persons experiencing chronic homelessness and 2) families being diverted from the shelter system.[4]

In July, 2014, Rhode Island joined the Zero 2016 campaign, a national movement assisting communities to reach functional zero for the numbers of chronic homeless individuals and homeless veterans, and began using the Service Prioritization Decision Assistance Tool (SPDAT) assessment to identify the state's most vulnerable persons and prioritize them for housing. Volunteers and professionals performed the VI-SPDAT (a shorter version of the SPDAT meant to identify vulnerabilities) in in late summer 2014 and March 2015. The following data was collected during these outreach efforts and

[3] National Alliance to End Homeless, State of Homelessness Report 2014, www.naeh.org
[4] RI Homeless Management Information System

represent the literally homeless persons who chose to participate in the surveys. Many had long term histories of homelessness. In addition, they had reported drug and/or alcohol abuse or visiting the emergency room for mental health reasons.

Unmet need: There is a need for affordable housing with supportive services that focus on housing retention. There is also a need for additional programs at both ends of the housing continuum, Housing First and Sober Housing models.

What the state is doing to address the need: The state has committed to homeless outreach, Housing First and permanent supported housing as its strategy to reduce behavior disorders among people experiencing chronic homelessness. This has been consistent in the design of the CABHI and PATH grants, staff's leadership on the CoC's Plan to End Homelessness and the Governor's Interagency Council on Homelessness**.** The State has established a permanent funding stream for rental subsidies for individuals and families experiencing long term homelessness. BHDDH is working with the Division of Medicaid to establish a Housing Stabilization service package reimbursable by Medicaid. Key services that are needed by this population are not provided and/or funded by the current service system. Chief among them are the often-long-term engagement services needed to bring alienated individuals to accept substance abuse services along with the medical, financial, employment and recovery services. Case management and care management are equally important services that are typically not funded sufficiently to meet this group's needs. The use of peers to both engage and case manage people experiencing chronic homelessness with a substance user disorder is a promising practice that has had only limited use in Rhode Island. The state has requested that Medicaid allow for housing support services as part of its Medicaid Waiver. The Center for Medicaid Services has not yet acted on this request.

BHDDH has received the Cooperative Agreement to Benefit Homeless Individuals (CABHI) grant through the SAMHSA. This grant will provide permanent supportive housing, treatment and recovery services to 300 individuals over 3 years. Key components to this program are peer specialist, who will have been certified and trained through the Peer Recover Specialist program funded through the Block Grant.

Services for persons with or at risk of having substance use disorder and/or SMI/SED

The Truven Study notes some broad indicators of Rhode Island's problems with substance use disorders. It notes that the state has the 7th highest rate in the nation for illicit substance use by young adults and adult dependence or abuse of illicit drugs and of deaths attributed to narcotics or hallucinogens.

The most recent (2013) NSDUH consumption data indicates that Rhode Island continues to be below the national average for underage alcohol and tobacco use, although it continues to exceed the national rate for past month marihuana use. Alcohol abuse and dependence across all age groups has continued to exceed the national average since 2004, although it is dropping along with the national rate. Underage prescription drug use continues to be below the national average. Drug abuse or dependence across all ages has continued to exceed the national average since 2004. Past month use of alcohol, marihuana and illicit drugs has remained higher than the national average across all age groups since 2004. Non-medical use of pain relievers has also remained above the national average for all age groups since 2004. The percentage of people needing but not receiving drug treatment has surpassed the national average across all age groups since 2004. Similarly, the percentage of Rhode Islanders needing but not receiving alcohol treatment has continue to surpass the national average across all age groups since 2004.

Both the NSDUH data and the Truven study describe a state with high levels of drug and alcohol use and overall insufficient availability of treatment services.

By increasing capacity and access to treatment and recovery support services, Rhode Island will reduce the number of deaths related to substance misuse; decrease the prevalence of substance use disorders; increase abstinence rates; decrease overutilization of costly healthcare services such as emergency department visits and hospitalizations; reduce alcohol consumption and use of opioid medications; reduce crime related to substance misuse and improve overall health outcomes. The Department will continue to focus on:

- Monitoring compliance of the state's BHOs with state regulations and contracts
- Enhancing the use of peer supports by supporting peer training and certification and by using peer recovery specialist to address substance abuse treatment needs. For example, peer recovery specialists are engaging with overdose survivors starting with first contact at hospital emergency departments and continuing to support them to seek treatment and recovery services; providing outreach in high need community "hot spots" and working with pregnant women who inject drugs.
- Providing adequate levels of residential treatment, detox and step-down
- Developing treatment programs that address age specific needs that consider LGBTQI.
- Supporting Medication Assisted Treatment through Centers of Excellence
- Contract for the support and monitoring a certification process for recovery housing
- Continue accessing trends and provide educational trainings regarding evidence based practices.

Persons Who Inject Drugs:

1. **Overdose deaths from illicit drugs.**

Unmet need: Sufficient services to prevent overdose deaths

Problem description and Data:

Since 2010, RI has consistently surpassed the national average for drug-related overdose. RI also has consistently fared worse than all other northeastern states in terms of drug-related overdose deaths) per *Death certificate data: National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Mortality Detail files, 2010-2013*. RI was ranked 6th in the nation for age adjusted rate for overdose death (23.4%) in 2014, per the Centers for Disease Control's National Vital Statistics System.[i] However, data were unavailable for Connecticut. A key limitation of these data is that drug-related overdose deaths could be due to prescription drugs (e.g. opioids, benzodiazepines, stimulants) or street drugs (e.g. alcohol, cocaine, amphetamines, and heroin).

Rhode Island has experienced a 50% increase in overdose deaths from 2011-2016. Similar to states across the country, deaths caused by prescription drugs have leveled. RI has seen a decrease by 40% since 2011, deaths from illicit drugs have risen by 250% and deaths caused by a combination of illicit drugs and prescription opioids are up by a third since 2011. Illicit drugs mixed with Fentanyl overdose deaths have increased 20-fold since 2009 and is exacerbating the overdose crisis.

As of December 12, 2016, there were 1,471 reports of overdose, of which 57 resulted in death, 1,152 had been discharged from the hospital at the time of the report and 262 had been admitted to the hospital but not discharged. Heroin was the cause of 58% of the overdoses.

What the Department is doing to meet this need? BHDDH provides a number of approaches to reducing opioid overdoses. These include:

- Navigation Recovery Program
- Help Line, a 24 hour, 7 day a week to provide education, referral or emergency response for substance use and opioid use disorders
- Medication Assisted Treatment (see description in Environmental Factor section 15)
- Step-down and detoxification services. The Department added regulations for all licensed treatment facilities to assess for appropriate ASAM level of care placement and then reviews implementation during audits
- Naloxone distribution in collaboration with the Department of Health. Department of Corrections, EMT's and local and state police departments
- Participation of licensed BHOs in the state's Prescription Drug Monitoring Program.
- Program participation in the "Current Care" information system which allows providers to share treatment information with each other for consenting patients
- Support Community Recovery Centers and advocacy programs
- Initiated regulations that address mandatory instruction of Narcan use to all clients with an opioid use disorder or who are high risk.
- Support programs that train and supply Narcan to the community at large.
- The Department provide trainings in the community for prescribers to acquire CME's on minimizing the risks in Prescription Prescribing.
- Provided six "Grand Rounds" training on various addiction topics to local Universities.
- Utilizes media and bill board support to target access to treatment referral support through the "Addiction is a Disease, Treatment is available and Recovery is possible" campaign.
- Sponsor and support annual *Rally4Recovery* event which had Narcan informational booths and personal sharing's from individuals and family members on the joy of recovery.
- Through the STR grant the Department is placing Nurse Care Managers in identified high need communities; increasing the capacity of regional prevention task forces to provide education on opioid use disorders in high schools and in the community; enhancing the Opioid Treatment Programs' access to psychiatrists and fentanyl testing for clients and developing a statewide communications' campaign.

Plan: The Block Grant-funded peer recovery specialists program will address people who inject drugs, opioid overdoses and other substance abuse-related problems by funding four activities:

- Early intervention in emergency rooms by trained peers with individuals experiencing overdoses. The peers follow the individuals and support them in seeking treatment and recovery services. Outreaching to people who inject drugs in "hot spot" areas of high drug use.

  Using SATBG funds, BHDDH partnered with The Providence Center's Anchor Recovery Center, one of Rhode Island' s peer recovery organizations, to develop a peer-run intervention, AnchorED, in eight of the ten state's hospital emergency departments and three walk-in Urgent Care's. BHDDH and the Anchor Recovery Center developed a program specifically to address the need for Certified Peer Recovery Specialists to be on call 24 hours a day,7 days a week to respond to individuals being treated for accidental overdose. The Recovery Specialists meet with the individual survivors and their families, link them to treatment and recovery resources, provide education on overdose prevention and the use of Naloxone, provide additional resources and maintain contact after discharge to offer additional recovery supports. The program has responded

to 230 overdose survivors since it began, some individuals report overdosing multiple times over the course of relapse and recovery. Of these, 83% have been referred to some form of a recovery support service. While the survivors ranged in age from 15 to 77, the highest rate of incidence was 21 to 28. 77% of the 230 had never had any formal treatment prior to their involvement hospitalization and contact with the peers involved in the AnchorED program. Survivors and hospital staff state that this program has caused a culture shift within the Emergency rooms. The concept of addiction being a disease and the lessoning of the stigma previously attached to the use of drugs has been visible noticeable.

The Department has expanded to the Recovery Centers through an RFP and will soon offer three sites across the State increasing accessibility to a variety of recovery programs.

Hepatitis C: This disease, which is commonly spread through intravenous and intranasal drug use is five times more common among "Baby-boomers" born between1945-65, poses substantial risks to PWID, particularly those who are older. Because there are no symptoms of the disease, many people do not know they have it until it leads to life-threatening liver disease and other illness.

Unmet Needs: Lack of awareness among PWID that they are at high risk for or may already have Hepatitis C. Lack of awareness among PWID of risk factors, preventive measures and effective treatments for Hepatitis C.

Data: 358 (5.6%) adult SA clients within the BHDDH-licensed treatment system were reported as having a "life threatening viral illness." Additionally, 1015 (15.9%) were reported as having Hepatitis C.

Plan: In collaboration with the Department of Health, BHDDH developed a public awareness information packet to be distributed through its treatment providers and through the Rally 4 Recovery. The packet contains information on Hepatitis C risk factors, prevention measures, test and treatment sites, and will include the CD Hepatitis C questionnaire. Free Hepatitis C testing and Hepatitis C information will be available at the Rally4Recovery event, September 16, 2018, which draws thousands of Rhode Islanders.

Adolescents who have substance or mental health problems

Unmet Needs: Adolescence and early adulthood are when most serious mental illness and substance abuse starts. Research has shown that adolescents are particularly susceptible to developing mental illness due to rapid development, brain growth, and newly manifesting genetic risk factors. Roughly half of all lifetime mental disorders start by the mid-teens and three-fourths by the mid-20s. Young adults who are transitioning from adolescence to adulthood also face significant substance abuse-related challenges, which in Rhode Island are deepening in many respects. During this stage of life, many of the supports (emotional, institutional, financial, etc.) that living in families or foster care systems and attending schools and other community activities have provided are withdrawn. Many individuals with emerging substance use disorders become more vulnerable during this stage of life. The separation from family and community resources and supports during this life stage is compounded by the disconnection between the child and adult public systems. Individual youth generally move from a more nurturing, comprehensive,

remedial and determined environment to one that is less controlling, less supportive, less remedial, less easy to access, more fragmented and more confusing.

In summary, youth and young adults face several significant barriers to getting the treatment and recovery supports they need:

- The experience of alienation that can come with the disconnection from family and the institutions that support children and, at the same time, the difficulty of understanding, trusting and accessing adult supports
- The lack of services that are appropriate for this stage of life
- The lack of age-appropriate recovery/resiliency supports
- The lack of a systemic "locus of responsibility" for people in this age-group

Data:

Claim data from the MMIS for State Fiscal year 2014 identified 10,484 unique recipients ages 16-25 who incurred a claim having a primary diagnosis in the range of Mental Disorders. 3,521 unique recipients, ages 16-25, incurred a claim having a "Serious" Mental Disorder as a primary diagnosis. The most prevalent primary diagnosis in this range was for Episodic Mood Disorder at 91.4% of the recipients, followed by Other Non-Organic Psychoses at 12.8. Of the 3,217 recipients who incurred a claim having an Episodic Mood Disorder, 36.8% were Major Depressive Disorder, recurrent.

According to the 2012/2013 NSDUH, 11.32% of RI's 12-17 year old and 9.74% of 18-25 year old reported at least one major depressive episode in the past year. Among 18-25 year old in RI, 4.47% report a serious mental illness in the past year; 19.93% report any mental illness and 7.34% had serious thoughts of suicide.

About one in five teenaged youth suffers from diagnosable mental health disorders, yet only approximately 20% of teens aged 12-17 received treatment.

Rhode Island's adolescents and young adults continue to experience the need for treatment for substance use disorder but don't necessarily receive services. Ten years of data from the NSDUH concerning the percentage of the population, by age range, who meet the diagnostic criteria for abuse or dependence of alcohol or drugs show that RI is consistently above the national averages across the 12-17 and 18-25 age groups. The 18-25 age range is consistently higher than the 12-17 for each year of data reported and in many cases the percentages are double, triple or quadruple that of the 12-17 age range.

Approximately 10 years of data from the National Survey on Drug Use and Health concerning the percent of the population, by age range, who need but don't receive services for substance use disorders shows that Rhode Island exceeds national averages across the relevant age groups for both alcohol and drugs. As noted above with respect to tables 1 & 2, the percentage of the 18-25 age group needing but not receiving treatment for alcohol use is double, triple and in some select time frames almost quadruples that of 12-17 year old. The ratios of RI to US are consistently higher among the 18-25 age group as well.

Plan:

Rhode Island's plan to address these issues involves both system development and direct service provision. The "Now is the Time/Healthy Transition" grant-funded initiative is the primary mover of this process for mental health disorders. At a systems level, the grants involve collaboration between BHDDH, DCYF and EOHHS and two of the state's CBHOs to develop services specific to the needs of youth/young adults ages 16-25. Services will include community awareness to reduce stigma and other barriers to help-seeking, outreach and engagement, assessment, referral and services specifically for those experiencing first episode of SMI. At the systems level, the goal will be to establish a "locus of responsibility" for services to this age group. This will involve local community oversight, a statewide oversight body that will be a committee of the Governor's Council on behavioral Health, development of collaborative funding and the institutionalization of policies that will support these innovations past the life of the grant. BHDDH has also received a State Youth Treatment Planning grant, which supported the development of state-level policies to institutionalize substance abuse services to youth/young adults. A key objective of these initiatives will be to nurture an effective peer capacity, both to aid in outreach, engagement treatment and recovery and to give young consumers a leading voice in the development of the service system.

Efforts will also be made to develop alternatives to adolescent residential treatment for SUDs the State has been awarded a State Youth Treatment Implementation grant that will bring Seven Challenges to four communities.

Finally, BHDDH will work with the contract for training for peer recovery services to develop resources that are age-appropriate to youth/young adults, and will support the development of young peers to help with that effort.

Women who are pregnant and have a substance use and/or mental disorder

Unmet Needs. Public funding for residential treatment for mother with substance use disorders and their infants have become increasingly inadequate, with lengths of stay shortened, which. increases chances for the moms to relapse, the curtailed amount of time in treatment is inadequate for the DCYF to successfully reunite families.

The incidence of RI infants born with Neonatal Abstinence Syndrome, (NAS) has risen to more than 95 babies in this past year at Women and Infants Hospital alone. At present RI has no detox services for opioid dependent pregnant women who are unwilling to use methadone or Suboxone. Although use of medication assisted treatment helps stabilize the mothers, helps reduce criminal activity and promotes better connections to prenatal care, when they do reach out they are often met with judgmental and punitive responses from social service agencies who are unfamiliar with treatment benefits. Many of these mothers do not disclose their drug use during pregnancy due to stigma around NAS and substance use disorders in general. The use of Peer Recovery Specialists for pregnant moms with substance abuse disorders is essential for this often-marginalized population, and can assist both moms and infants with resources to promote the best chances for a safe recovery.

Parents with substance use and/or mental disorders who have dependent children (needs to include DCYF info)

Services for persons with or at risk of contracting communicable diseases:

Tuberculosis – Rhode Island continues to have a low incidence of tuberculosis infection. According to Department of Health data, there were a total of 12 cases of the disease in 2016. The majority were among Hispanic people, and 16 of the 21 were among foreign born individuals. The state will continue to require, through licensing regulations, all Medication Assisted Treatment, residential, and medical detoxification treatment programs to provide or arrange for a physical, which included necessary laboratory work to include tuberculosis (PPD-Mantoux) testing. In addition, the contracts with treatment programs specify that the program must routinely make available tuberculosis services directly or through arrangements with other entities to all individuals receiving treatment for substance abuse. SSA staff will continue to review client records to test compliance with licensing regulations as part of the routine site visit.

Primary Prevention

State Epidemiology and Outcomes Workgroup

The State Epidemiological Outcomes Workgroup (SEOW) is administered by BHDDH and reports results of its activities to the Rhode Island Governor's Council on Behavioral Health. The mission of the SEOW is to institutionalize data-driven planning and decision making for the purposes of state and community level planning in the areas of substance use, abuse, and consequences, and mental illness across the State of Rhode Island

The SEOW is charged with the following tasks: (1) Develop a set of key indicators, micro level to macro level, to describe the magnitude and distribution of substance use, abuse, and consequences, and mental illness as well as to develop a set of key indicators, micro level to macro level, of risk and protective factors associated with substance use, abuse, and consequences, and mental illness across the State of Rhode Island; (2) Identify, collect, manage, analyze, and interpret data on the prevalence of substance use, abuse, and consequences, and mental illness; relevant risk and protective factors at multiple ecological levels; (3) Based on these data, develop and communicate state-level and community-level epidemiologic profiles for promotion, prevention, treatment, recovery and policy implications for Rhode Island healthcare system; (4) Inform and recommend priorities for the State of Rhode Island based on the community and state-level epidemiological profile; and (5) Maintain and expand a systematic, ongoing monitoring system of the prevalence of substance use, abuse and consequences, mental illness, and relevant multilevel risk and protective factors.

The SEOW utilizes national and local data drawn from a variety of sources and includes indicators of behavioral health-related consequences, incidence and prevalence of substance use and mental health disorders and associated intervening variables including risk or protective factors. The data is primarily archival or survey data. Data is collected on age ranges across the lifespan, race/ethnicity, gender, sexual orientation, geography, disability and military status, although not all data sets permit this level of disaggregation. Data sources utilized by the SEOW include but are not limited to: Behavioral Risk

Factor Surveillance System, Pregnancy Risk Assessment Monitoring System, Youth Risk Behavior Surveillance System, National Survey on Drug Use and Health, National Vital Statistics System, Treatment Episode Data, US Census, Fatality Analysis Reporting System, Uniform Crime Reports, US Department of Housing and Urban Development, Bureau of Labor Statistics, RI Department of Children, Youth and Families, RI Kids Count, CDC School Health Profiles, National Survey of Children's Health, State Health Facts, RI Department of Education's Survey Works, RI Department of Behavioral Healthcare, Developmental Disabilities and Hospital's Behavioral Health On-Line Data system (BHOLD), and the RI Alcohol Purchase Survey.

Major accomplishments in 2016 included updating the state epidemiology profile and including a set of national and state level mental health indicators and additional indicators related to consumption and consequences of opioids including prescription drugs; presenting key findings from the state epidemiology profile to the Governor's Council on Behavioral Health and other key stakeholders across the state and discussing implications for behavioral health planning; analyzing data from the 2015 Alcohol Purchase Survey; and drawing the sample for the 2016 administration, providing training on use of Geographical Information Systems (GIS) mapping for behavioral health planning and policy work; and preparation of updated and expanded community profiles.

Major accomplishment in 2017 included the completion of community epidemiologic profiles for each of Rhode Island's 39 municipalities. Training was provided on use of Stata for behavioral health data analysis and interpretation. Anticipated activities include creation of a drinking/alcohol misuse data brief; creation of agency-specific behavioral health data briefs for the Department of Transportation and Department of Children, Youth and Families and; updating the State Epidemiology Profile in the late winter of 2017. The Prevention Resource Center, using SEOW findings created data briefs from substance specific state data on opioids and prescription drugs and youth marijuana use.

Other key stakeholders across the state, analyze data from the 2017 Alcohol Purchase Survey and draw the sample for the 2018 administration, revise the needs assessment guide and refine the qualitative data collection tools included in the guide, and provide additional data to respond to the SABG application.

Emerging Needs in the Workforce

Rhode Island has documented both strengths and weaknesses of its current substance abuse prevention and treatment system throughout its strategic plan (See *Rhode Island Amended Strategic Plan for Substance Abuse Prevention 2016-2019*). Our state action plan for an integrated system of care includes the development of a qualified workforce to meet the unique treatment and prevention needs of individuals with co-occurring disorders. This includes, but is not limited to, ensuring the capacity of the workforce is level across communities. This would mean that regardless of where an individual working in the field is located, efforts are made across communities and the State to ensure that the workforce has the same level of competency to deliver prevention services. Opportunities exist to explore enhanced infrastructure to increase awareness and capacity among stakeholders within the system, while creating greater integration and efficiencies of the system as whole.

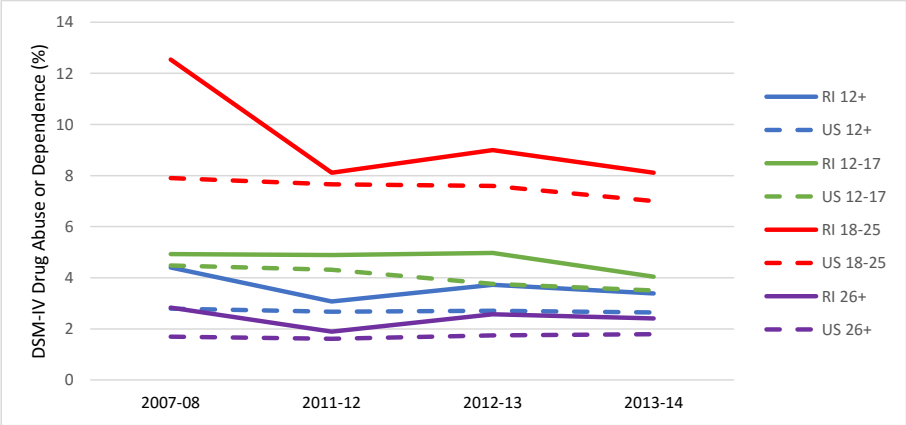
There is a need to have greater understanding of existing providers and the varying levels of readiness and capacity to affect change. A clear opportunity exists to improve workforce development strategies to

increase the capacity, knowledge, skills and organizational development of prevention and mental health promotion and treatment providers driven by sound practice and data-driven program planning. Through the implementation of our State's plan and leveraging existing opportunities within the system, this will allow RI to build upon its current foundation and support an evolving and on-going workforce development planning process.

Prevalence Data

RI vs. US DSM-IV Drug Abuse or Dependence by Age Group, 2007-2014

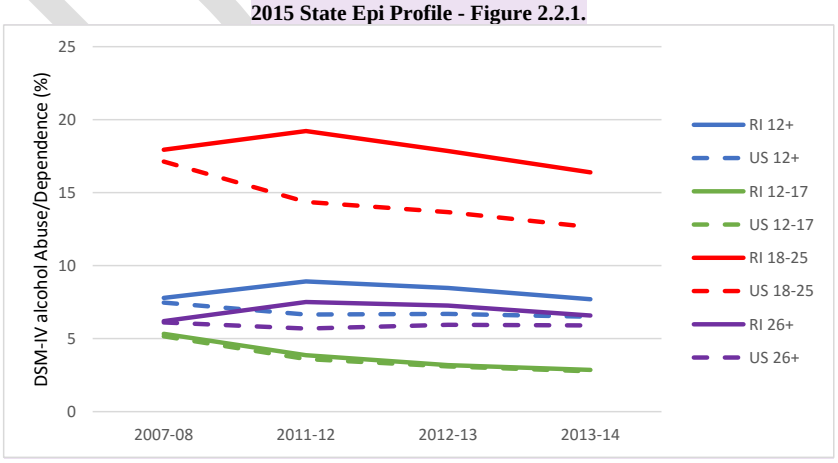
2015 State Epi Profile - Figure 2.1.4.



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

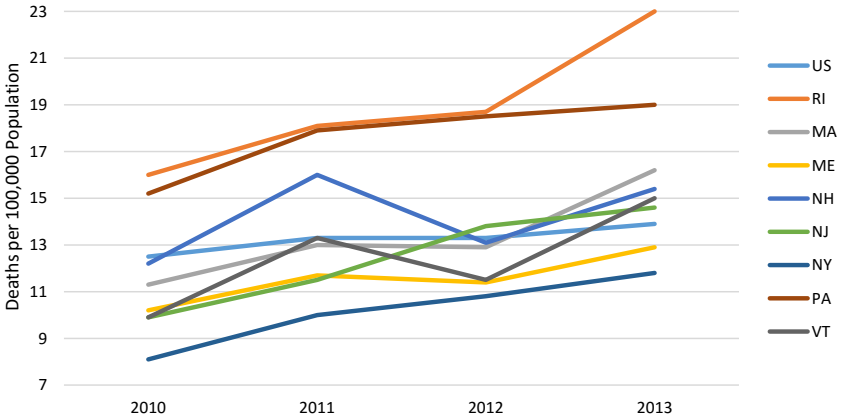
RI vs US DSM-IV Alcohol Abuse or Dependence by Age Group, 2007-2013

2015 State Epi Profile - Figure 2.2.1.



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

Figure 2.4.2. Drug-Related Overdose Deaths, 2010-2013

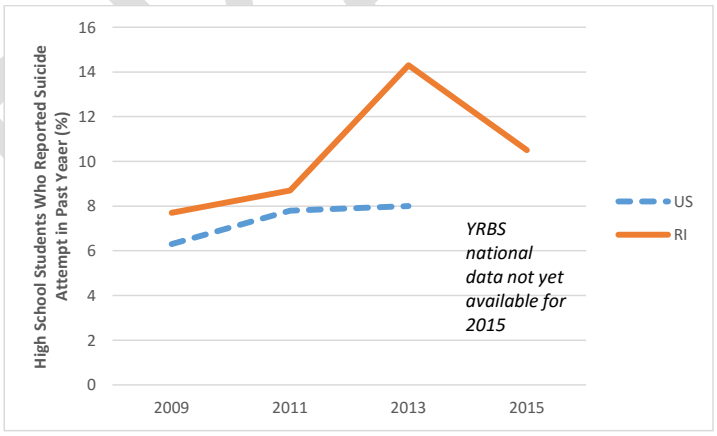


Source: Death certificate data: National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Mortality Detail files, 2010-2013. **2015 RI State Epi Profile.**

Commented [RC(1]: You don't ever describe these tables in any narrative. You should point out how RI is higher than the US for all ages for drug and alcohol abuse and dependence, particularly 18-25 (though it is decreasing).

Also, discuss the overdose chart

RI vs. US High School Students Grades 9-12 Who Attempted Suicide in the Past Year, 2009-2015



Source: Youth Risk Behavior Survey, Centers for Disease Control

While DSM-V diagnoses of dependence or abuse are potentially changeable with primary prevention strategies, it will take considerably longer than the time frame covered in this strategic plan. Similarly, while primary prevention efforts are important to stem the opioid overdose crisis in Rhode Island, we are

restricted to using primary prevention funds for the purposes of educating and informing the community and partners/stakeholders about the risk of overdose and effective strategies for curbing the overdose epidemic.

Lastly, the percentage of youth who reported attempting suicide as compared to US percentages overall is slightly elevated[5]. This selection of priority consequence is based on the ability to reduce suicide attempts by addressing shared risk and protective factors between substance abuse and suicide.

CONSUMPTION PATTERNS - Priority Consumption Patterns for 2016-2019 Strategic Plan for Substance Abuse Prevention

The following priority consumption patterns will be targets for primary prevention strategies based on the following criteria: severity as compared to US rates, unfavorable trends, to maintain primary prevention efforts that have resulted in reductions in use or associated risk factors. 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 timeframe in which measurable change would be expected is five to seven years, which extends beyond the time 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. Marijuana use by adolescents ages 12-17

B. Use of illicit drugs other than marijuana 12-25

C. Underage drinking 12-20

D. Youth use of tobacco or tobacco related products especially use of electronic nicotine delivery systems (ENDS).

Marijuana Use by Adolescents

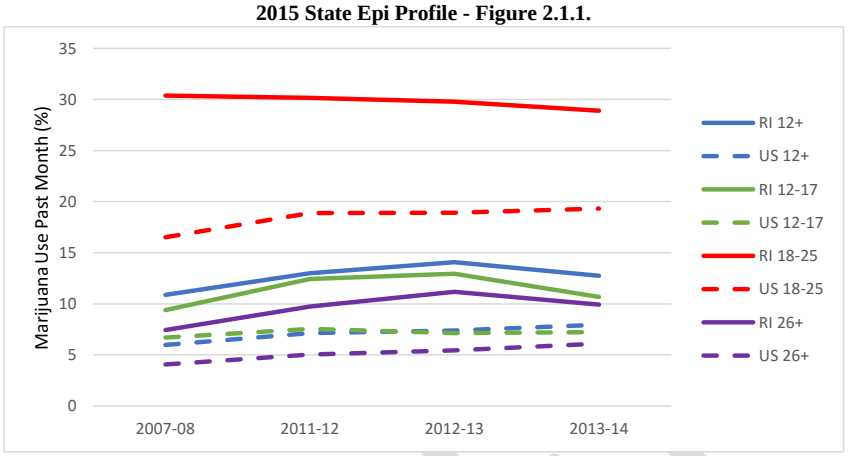
Regarding findings related to youth marijuana use: relevant tables from the 2015 State Epidemiological Profile include Tables 2.1.1 and 2.2.0 featuring trend data from 2007-2008 to 2013-2014 from the Substance Abuse Mental Health Services Administration's National Survey on Drug Use and Health, and Tables 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 to 2013-2014 but the rates were still considerably higher than the national average.

[5] 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

RI vs. US Marijuana Use Past Month by Age Group, 2007-2014

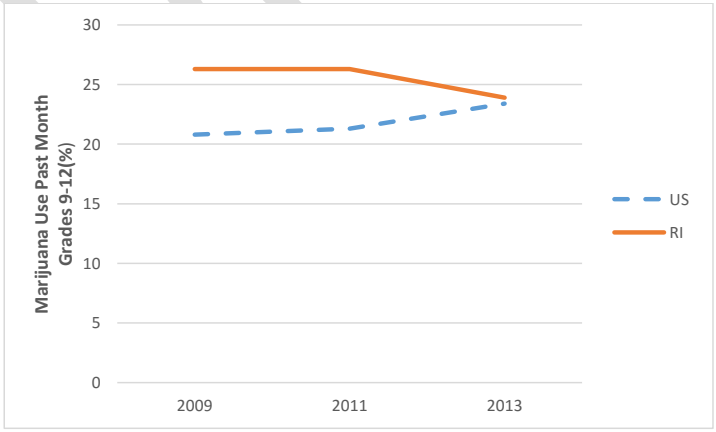
2015 State Epi Profile - Figure 2.1.1.



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 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, 2009-2013



Source: Youth Risk Behavior Survey, Centers for Disease Control

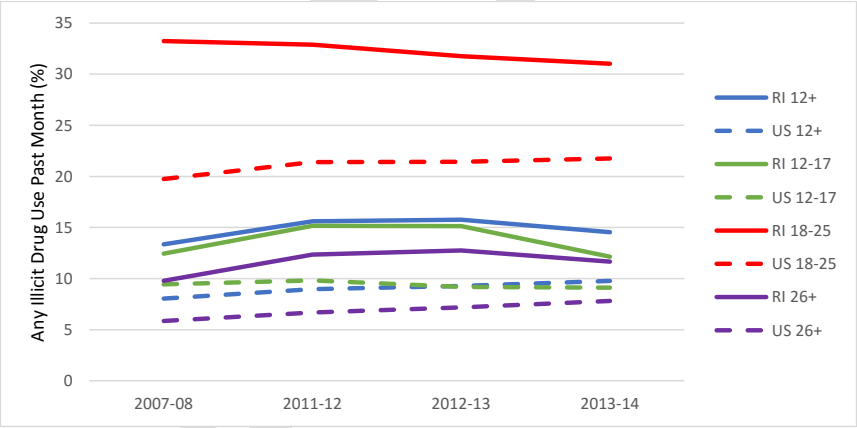
The Youth Risk Behavior Survey results indicate that among a statewide sample of RI high school students, underage marijuana use – even though there was a decreasing trend from 2001 to 2009 – remained the only underage substance use consumption indicator with prevalence greater in Rhode Island than in the rest of the country. Rhode Island's percentage has been declining since 2009 while the US percentage has been increasing.

Illicit Drug Use

According to data from the National Survey on Drug Use and Health (NSDUH) the doubling of the illicit drug use among persons older than 12 years of age in Rhode Island, from 3.0% in 2000 to 5.9% in 2007-2008, resulted in a 64% greater illicit drug use in Rhode Island in 2007-2008 than in the rest of the nation.

RI vs. US Any Illicit Drug Use Past Month by Age Group, 2007-2014

2015 State Epi Profile - Figure 2.1.0.



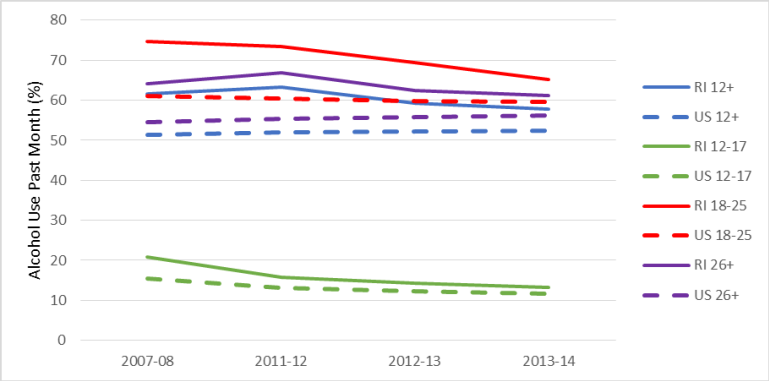
Source: National Survey on Drug Use and Health (NSDUH)

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

Rates of past month use of alcohol as reported in the NSDUH indicate that there is a downward trend between 2007-2008 and 2013-2014 across all age ranges although these rates are slightly higher than the national average across all age ranges.

Alcohol Use Past Month by Age Group, 2007-2014

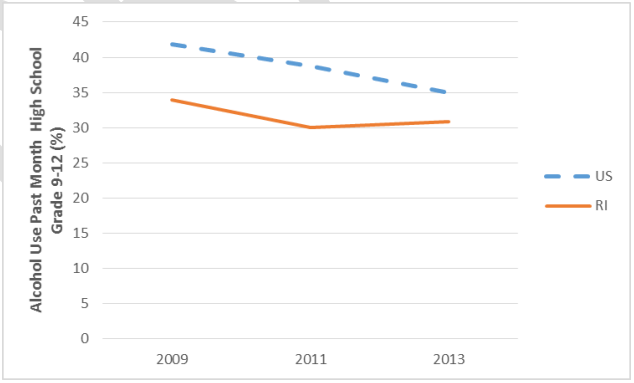
2015 State Epi Profile - Figure 2.2.0.



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 2009 -2013. As for rates of initial use prior to age 13 reported in the YRBS, *the rates of RI high school students reporting past month alcohol use which was once highest within the Northeast region is now below national averages*. Continued efforts to sustain these positive outcomes are necessary. See YRBS time trend chart below.

Youth Alcohol Use Grades 9-12, 2009-2013



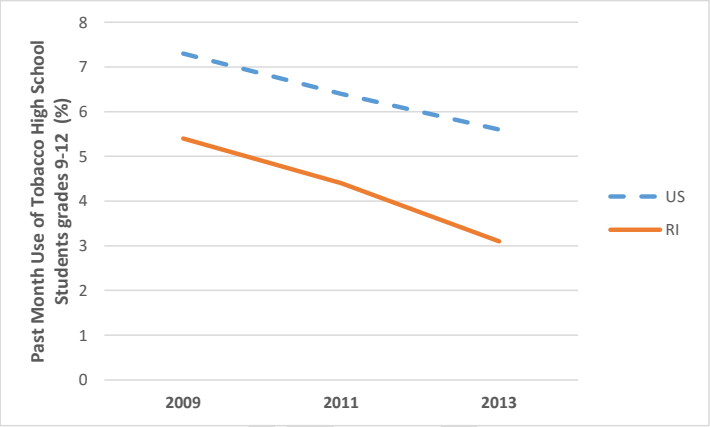
Source: Youth Risk Behavior Survey, Centers for Disease Control

Youth Tobacco Use

Even though the national trends for smoking also declined in this time period, reduction in these consumption trends was greater for Rhode Island. However, the 2015 Youth Risk Behavior Survey reported

40% of high school youth (grades 9-12) reported using electronic vapor products (electronic nicotine delivery systems). This constitutes an emerging need.

Youth Tobacco Use (Cigarettes) Grades 9-12, 2009-2013



Source: Youth Risk Behavior Survey, Centers for Disease Control

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 abuse. 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.

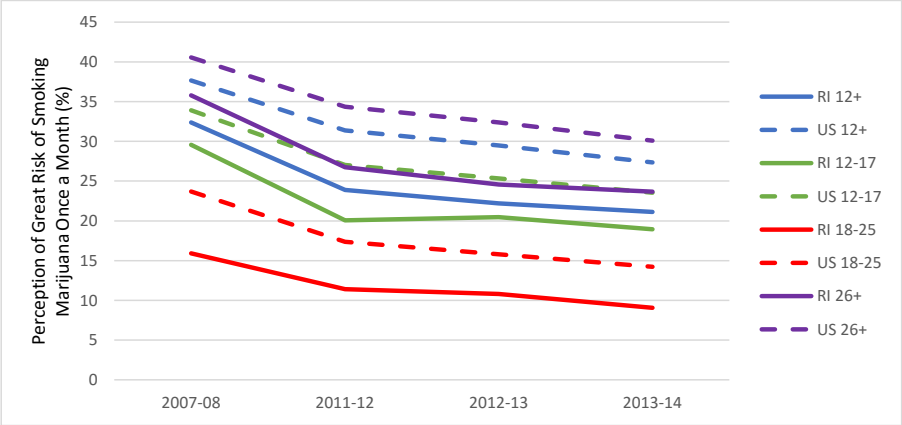
BHDDH provides funds through the Substance Abuse Prevention and Treatment Block Grant to RI communities to implement strategies to address these risk and protective factors. In addition, twelve Partnership for Success communities receive funding to implement evidence-based practices to reduce youth marijuana use and underage drinking through a SAMHSA discretionary award that ends in September of 2018. Changes in risk or protective factors are measurable within the timeframe covered in this plan, either by existing pre- or post-test surveys or the Rhode Island Student Survey.

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 focusing on **increasing the perception of risk of harm associated with chosen priority substance(s).** As Figure 2.1.2 shows, Rhode Islanders, regardless of age have a decreasing perception of risk for smoking marijuana once a month. This is likely due to the increase in legalization of or plans to legalize recreational marijuana in the country and in New England.

RI vs. US Perceptions of Great Risk of Smoking Marijuana Once a Month by Age Group, 2007-2014

State Epi Profile – Figure 2.1.2.



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

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 18 for tobacco. Currently, marijuana possession and use is illegal in Rhode Island. 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.

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.

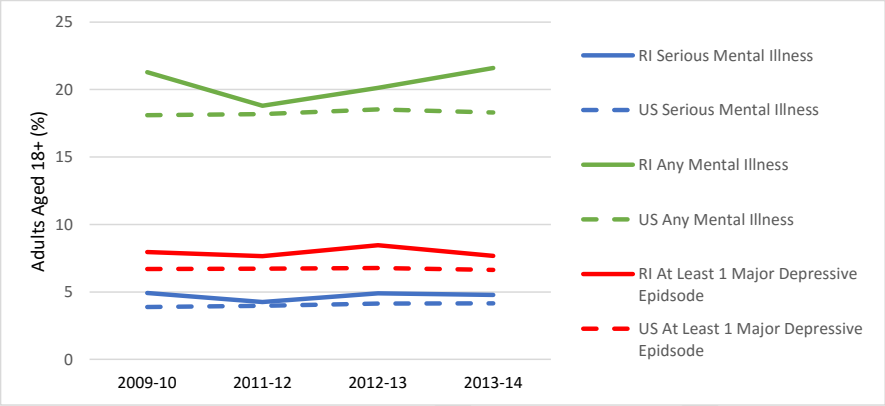
MENTAL HEALTH

RI fares 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 has 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 (See State Table 2.3.2).

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

RI vs. US Adult Past Year Mental Health, 2009-2014

2015 State Epi Profile – Figure 2.3.2.



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

[i] http://www.cdc.gov/drugoverdose/data/statedeaths.html retrieved 5/2/2016.