

Rhode Island

UNIFORM APPLICATION

FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT and COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 09/01/2017 8:07:37 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2018

End Year 2019

State SAPT DUNS Number

Number 111415381

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH)

Organizational Unit Division of Behavioral Health

Mailing Address 14 Harrington Road

City Cranston

Zip Code 02920

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Rebecca

Last Name Boss

Agency Name Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

Mailing Address 14 Harrington Road

City Cranston

Zip Code 02920

Telephone 401-462-0917

Fax 401-462-3204

Email Address rebecca.boss@bhddh.ri.gov

State CMHS DUNS Number

Number 111415381

Expiration Date 5/11/2013

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

Organizational Unit Division of Behavioral Health

Mailing Address 14 Harrington Road

City Cranston

Zip Code 02920

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Rebecca

Last Name Boss

Agency Name Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

Mailing Address 14 Harrington Road

City Cranston

Zip Code 02920

Telephone 401-462-2339

Fax 401-462-3204

Email Address Rebecca.Boss@bhddh.ri.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

Submission Date 9/1/2017 8:06:25 AM

Revision Date

V. Contact Person Responsible for Application Submission

First Name Michelle

Last Name Brophy

Telephone 401-462-2770

Fax

Email Address michelle.brophy@bhddh.ri.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
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Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Rebecca Boss

Signature of CEO or Designee¹: _____

Title: Director, BHDDH

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2018

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as required by
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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Rebecca Boss

Signature of CEO or Designee¹: [Signature]

Title: Director Date Signed: 8/11/17

mm/dd/yyyy

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name

Rebecca Bass

Title

Director

Organization

Rhode Island Dept. of Behavioral Healthcare, Dev. Disabilities,
& Hospitals

Signature:



Date:

8/21/17

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
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Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
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6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
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10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
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16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

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Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Rebecca Boss

Signature of CEO or Designee¹: _____

Title: Director, BHDDH

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:



State of Rhode Island and Providence Plantations

State House
Providence, Rhode Island 02903-1196
401-222-2080

Gina M. Raimondo
Governor

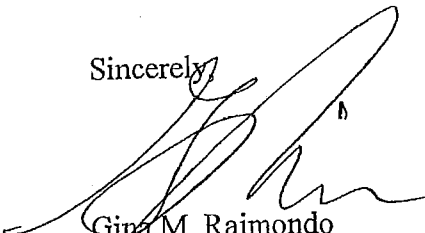
July 24, 2017

Wendy Pang
Grants Management
SAMHSA
1 Choke Cherry Road
Rockville, MD 20857

Dear Ms. Pang:

I am writing to notify you, Director Rebecca Boss of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, is authorized as my designee to sign any required documents for the Projects for the Assistance in Transition from Homelessness (PATH) grant, the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants (including the Annual Synar Report) for the tenure of my role as Governor of the State of Rhode Island.

Sincerely,



Gina M. Raimondo
Governor

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

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The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee:

Rebecca Boss

Signature of CEO or Designee¹:

[Signature]

Title:

Director

Date Signed:

8/11/20

mm/dd/yyyy

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
[Standard Form LLL \(click here\)](#)

Name	<input type="text"/>
Title	<input type="text"/>
Organization	<input type="text"/>

Signature:

Date:

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

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

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 Term 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) is the unified state agency with combined responsibility for child welfare, children's behavioral health and juvenile corrections. DCYF's vision is "Healthy Children and youth, Strong Families, Diverse Caring Communities and the mission is to "Partner with families and communities to raise safe and healthy children and youth in a caring environment". To carry out its vision and mission, DCYF provides a continuum of services ranging from home and community based services to residential service to address a variety of child and family needs. Services cover child abuse/neglect prevention, child protection, children's behavioral health and education, support services and services for youth with wayward and delinquent behaviors requiring community supervision or incarceration due to delinquency.

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 program is 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 disenrolled 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	<u>4,593</u>
TOTAL	13,371

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 for Children, Youth and Families (DCYF) is responsible for the child and youth behavioral healthcare system.

The Rhode Island Department of Children, Youth and Families (DCYF) is the unified state agency with combined responsibility for child welfare, children's behavioral health and juvenile corrections. The Department is statutorily designated (RIGL 42-72-5) as the "*principal agency of the state to mobilize the human, physical, and financial resources available to plan, develop, and evaluate a comprehensive and integrated statewide program of services designed to ensure the opportunity for children to reach their full potential. Such services shall include prevention,*

early intervention, outreach, placement, care and treatment, and aftercare programs. The Department shall also serve as an advocate for the needs of children.”

DCYF is guided by strong vision and mission statements that were developed by a cross-section of the Department’s staff and reflect DCYF’s system transformation built on communication and partnerships, as follows:

Vision- *Healthy Children and Youth, Strong Families, Diverse Caring Communities.*

Mission – *Partner with families and communities to raise safe and healthy children and youth in a caring environment.*

To carry out its vision and mission, DCYF provides a continuum of services ranging from community and home-based services to residential services. These services address a multitude of child and family needs including child abuse/neglect prevention, child protection, children’s behavioral health and education, support services for children and families in need, and services for youth with wayward and delinquent behaviors requiring community supervision or incarceration due to delinquency. This combined responsibility and service structure offers a tremendous opportunity for DCYF to work in concert with BHDDH and other state departments, community based agencies and family representatives to develop a statewide integrated system of care approach to meet the behavioral health needs of children, youth and their families in Rhode Island.

The State of Rhode Island is the smallest in the nation by geographic size and has a population of just over 1 million. Children under age 18 make up 20% of the population (211,875) according to the *2017 Rhode Island KIDS COUNT Factbook*. Other factors concerning children in Rhode Island noted in the *Factbook* include the following:

- Children are diverse in race, ethnicity, language and country of origin
- 22% of children identified as being Hispanic
- 9.8% describe themselves as lesbian, gay, or bisexual (2015 Youth risk Behavior Survey)
- 32% lived in single-parent households
- 20% of children lived in families with income below the federal poverty threshold
- Race and ethnic minority are disproportionally reflected in RI’s Training school and in out of home placements (DCYF)

On an annual basis, the DCYF provides services through the system of care to children, youth and families open to DCYF and to children, youth and families who are at risk of involvement with DCYF. Programs and Direct Services are delivered through the following programs or divisions:

- Child Welfare which includes Child Protective Services (including Intake) and Family Services;
- Juvenile Probation/Parole and Juvenile Corrections (Rhode Island Training School);
- Consolidated Youth Services (CYS)
- Children’s Community Services and Behavioral Health (CSBH)
- Family Care Community Partnership (FCCP)
- Prevention Campaigns, including promoting wellness, preventing child abuse, education on child safety

CSBH provides assistance to children and youth not open to DCYF in accessing some community based services through direct referral. Child Protective Services refer children, youth and families directly to the Family Care Community Partnership program (FCCP) which operates as a prevention and/or diversionary

program for children not open to DCYF. DCYF funds a family support organization that provides information, peer support and mentors to children and families at risk for mental, emotional and behavioral disorders and those children already diagnosed who are not open to DCYF.

Child Welfare

The DCYF is a state administered child welfare system with a centralized child protection operation with response times for investigations ranging from as immediate as 10 minutes to within 24 hours. Supported by federal funding, community liaisons are co-located in DCYF offices to assist families in connecting to community resources. For example, a nurse liaison from an Early Intervention program is working with DCYF's child protective services to implement a regularized referral process for children under the age of three to an Early Intervention program or other appropriate early child development and family support program. A domestic violence advocate is available to assist families and provides consultation for DCYF staff. Children involved with DCYF are at risk for mental, emotional and or behavioral disorders and focus of services is in prevention of further trauma and improving well-being.

Centralized Case Monitoring Units (CMU) work with families who receive differing levels of community-based prevention and family preservation services. This focus helps to maintain children at home without seeking Family Court involvement or transferring cases to the Family Service Units. The Intake and CMU staff work with the Family Care Community Partnerships (FCCP) to support their efforts in providing necessary services for families that are referred from CPS.

	2015	2016	2017
Number of completed Investigations	6969	6242	5262
Opening to CW	6,072	5,701	
Percent of children age 0 to 3 identified as a victim referred to ei service system	63%	65.5%	95%
# Transferring to JJ	49	41	
Average monthly # in congregate care	525	525	451
Average monthly # in out of state placement		78	53
Average monthly # of children in foster care (specialized, relative kin and not Kin)	1568	1578	1487

Children and families that are opened to DCYF after an investigation are assigned to the regional office that covers where the family lives. Each regional office has a Regional Director who oversees the Family Service Units (FSU) that are comprised of social case caseworkers, child support technicians and case work supervisors. The Family Service Units provide assessment and services through community resources to those children, youth and families, most of whom are in out of home care with legal involvement. DCYF staff work collaboratively with the child, youth, family, service providers, other state agencies, health plans and others to ensure that each child/youth receives the right services to meet their needs. A psychiatrist is on staff to consult on the use of psychotropic medications and behavioral health of children in DCYF's care.

Juvenile Corrections

The Rhode Island Training School (RITS) is the State of Rhode Island's only Juvenile Corrections and Detention facility which services youth between the ages of thirteen (13) and

nineteen (19) years old and is operated by the Department of Children Youth and Families (DCYF). The RITS operates three physically separated units located on the Howard Complex in Cranston, Rhode Island:

- A fifty-two (52) bed Detention Center (Roosevelt Benton Youth Assessment Center) of which 28 beds are in operation.
- A ninety-six (96) bed facility (Youth Development Center) for adjudicated youth who are serving sentences imposed by the Family Court. This facility has four (4) living units (Mods) each with twenty-four (24) beds. We are currently operating three of these mods; two are used for adjudicated male residents.
- One of the 24 bed mods is for female residents and houses both pre-adjudication (detention) and adjudicated residents. This mod is meant to have a capacity of 12 females in total.

There has been a steady decline in the average daily population at the RITS from 190 youth in 2001 to 77 youth in 2016 which is more than a 60% decrease in the average daily population as a result of the various initiatives and oversight. The total number of admissions (duplicated Adjudicated and Un-Adjudicated total) has decrease from 751 in calendar year 2014 to 606 admissions in calendar year 2016. The average length of stay for males is 47 days and for females is 41 days according to the Juvenile Detention Alternatives Annual report for CY 2016. The female juvenile offenders represented 14% of the average daily population in 2016.

The average age of residents is approximately 16.5 years old. The predominant population is recorded as being of minority status (72%); with African-American/Black residents making up 34%, Hispanic-Latino residents making up 25%, 9% of residents declaring other than Caucasian, and Asian residents making up 3%. Caucasian/White residents make up 28% of the population. Race and ethnic minority populations continue to be disproportionally reflected in the RI's Training School population.

Psychiatric services, mental health counseling, sex offender treatment and substance use treatment are provided to residents during their stay at the RITS based on identification of need. In the calendar year 2016, the following services were provided:

- psychiatric services
 - 68 Initial psychiatric Evaluations
 - 772 Psychiatric follow-up appointments
 - 80 Emergency psychiatric evaluations
 - 920 total visits in Psychiatry Clinic
- general mental health treatment 149 residents (117males/32 females).
- sex offender specific treatment program (9 males)
- substance use specific treatment
 - 87 residents who participated (73 males/14 females)
 - 55 residents were at inpatient level core substance abuse treatment program
 - 32 outpatient level.

Educational and Vocational programming are also a major component at the RITS and include a Barbering Apprentice Program, art program through AS220 and a very successful Culinary Program. Administrative Review Meetings support the youth's transition back to the community.

Over the past two years (2016 to 2017) the Home Confinement/Electronic Monitoring Program (HC/EM) has served over 500 high risk youth. Since 2012 when this program was created, 1235 youth have participated in this program with a success rate for youth remaining in their community of over 74%.

Probation and Parole

Youth on probation are assigned to a probation worker in one of seven regional offices. The number of youth on probation has continued to decrease over the past 8 years since 2009 when the Juvenile Detention Alternative Initiative (JDAI) was brought to RI by the Casey Foundation. From 2009 to 2014 there was a 55% reduction in the number of youth on probation.

In FY2017 the number of youth on probation has decreased to an average daily caseload of 470. An extensive array of services is now available to help youth including court ordered treatment such as Functional Family Therapy, MST, Preserving Families Network, Parenting with Love and Limits, Youth Transition Centers or temporary placement in a residential setting.

In July of 2015, Juvenile Probation implemented a new assessment protocol for youth adjudicated wayward or delinquent by the RI Family Court. The assessment process includes the use of a validated risk/needs assessment (the SAVRY) which utilizes structured professional judgement to identify the level of risk for re-offending and two behavioral health screens (MAYSI-2 and CRAFFT) to assess for mental health and substance abuse issues.

Through this assessment process, a youth's criminogenic needs are identified which can then be a focus of attention in service planning. Youth are re-assessed every six months or sooner due to a significant event such as a new charge or change in living arrangements. Using the risk/needs/responsivity principal, services can be identified for youth based on the level of risk, identified need areas, and other factors specific to the youth (age, gender, ethnicity, etc.).

In January of 2017 Probation initiated a unit (Assessment/Transition) specifically to conduct these assessments and to work with RI Training staff toward discharge planning for youth leaving that facility. We are currently working with the RI Family Court on initiating a plan to conduct the assessments on a pre-adjudicative basis to better assist the court in dispositional planning.

	2014	2015	2016
Opening to CW	6,368	6072	5701
# Transferring to JJ	78	49	41
# residents at RITS	751	695	606
Youth on probation		530	470

Youth Transition Centers (YTC): YTC is a public/private collaboration between a community services organization and Juvenile Probation/Parole for high risk youth on probation or leaving the Training School. Youth receive services in the community with an emphasis on strengthening families by integrating outreach and tracking services from the community services program. YTC provides both prevention and rehabilitative services to around 129 youth in FY 2017.

Wayward/Disobedient Diversion Services:

The following services were developed to assist in diverting youth from the juvenile justice system by providing services in the community. These programs have assisted in reducing the number of youth in the RI training school and on probation by providing services to address needs of youth and family.

Legislative Initiative Article 23:

This initiative (signed into law in 2001) ensures that appropriate community services have been offered to families and children prior to the filing of a wayward petition by virtue of a disobedient behavior petition with the Rhode Island Family Court. When a parent or guardian wishes to file a petition alleging that a child in their care is wayward by virtue of disobedient behavior, they contact the local police department

which, if appropriate, has a release of information signed by the parent or guardian and instructs the parent to go to the local agency approved by DCYF for an initial screening/assessment. An assessment and service plan are provided at no cost to the family. The agency then engages the family in a course of treatment/intervention or refers them to a more appropriate agency. During FY 2017, 253 youth received services from six community agencies.

Youth Diversionary Programs (YDP):

YDP, which was established in 1993, is a community based program for youth between the ages of 9 and 17 who are at risk of being involved in the juvenile justice system. The goals of the YDP are to divert youth from the juvenile justice system and to prevent youth from involvement with DCYF. Crisis intervention, family mediation, advocacy, counseling and referrals are provided for up to 90 days. Five community agencies have provided services to 312 youth.

Services for Transition Youth

Chafee Foster Care Independence Program

DCYF is the state agency responsible for the administration, supervision and oversight of all programs and services required and funded under the Chafee Foster Care Independence Program (CFCIP), including the National Youth in Transition Database (NYTD) requirements and the ETV program. As such, DCYF is responsible for providing youth in foster care and formerly in foster care with youth development services and supports to help transition to adulthood and achieve permanency and self-sufficiency. DCYF is committed to assisting all youth who are leaving its care to enter adulthood successfully.

The Consolidated Youth Services (CYS)

DCYF designed the CYS Program to ensure older youth in the care and custody of the DCYF, as well as youth aging out and former foster youth have the tools, resources and opportunities that will increase the likelihood they will successfully transition from DCYF care. Services are available to all youth ages 16-21 who are in foster care or who were in foster care after their 16th birthday, including youth who left foster care for kinship guardianship or adoption after their 16th birthday. The CYS program either directly or through collaboration with other agencies, provides financial support, housing, counseling, employment, mental/physical/sexual health, food assistance, educational and other appropriate services. These services complement a youth's own efforts to achieve self-sufficiency and assure that program participants recognize and accept personal responsibility for preparing to transition into adulthood.

As of June 6, 2017 there are 1,472 unduplicated active participants across all CYS programs. The CYS Program includes the following direct and/or indirect service components:

Young Adults Establishing Self Sufficiency (YESS):

YESS supports former foster youth as they age out of the DCYF system and transition to adulthood. This voluntary aftercare service provides assistance with room and board, emergency services and assistance in accessing other income and support services for young adults between the age of 18 and 21. In FY 2017 YESS aftercare services were provided to 303 youth.

Life Skills Assessment and Individualized Life Skills Education:

The Casey Life Skills Assessment (CSLA) is used statewide to conduct Holistic Youth Assessments (HYA) on youth referred for an assessment by DCYF. This assessment tool is strength-based and widely accepted as a best-practice model. The CSLA addresses all key

transition domains, included permanency and the youth's level of confidence in their future. Other supplemental topics include education, pregnancy, parenting infants and young children, youth values, homeless youth, gay, lesbian, bisexual, transgender, and questioning youth (GLBTQ), and American Indian culture. As of May 24, 2017 there were 215 youth referred for a life skills assessment and 112 youth have completed their life skills education.

Real Connections:

Real Connections ensures that all youth leave state care with positive, permanent adult connections and options for a successful future. Real Connections works in collaboration with DCYF and other partner organizations to implement innovative family finding techniques to advance permanency. Strategies used to identify potential mentors include eco-mapping, case recording-mining to search for individuals formerly connected to the youth; and Seneca Searches an online search technology to access public records in order to find connections related to the identified youth. Real Connections is available to youth ages 8-20 and employs a mentoring model to strengthen those relationships that are not immediate placement options but may become an important adult resource. If no adult connection from within the youth's own network can be identified youth are matched with a mentor from the community. Every identified adult connections undergo a 5-hour mentor training and are supported for a minimum of a year. There are 102 active participants as of 6/5/2017 of which 58% are currently matched with a mentor.

The Voice: Youth Advocacy & Leadership Board:

The Youth Advocacy & Leadership Board for the Department of Children, Youth & Families provides young adults, ages 14-24, a platform to use their experiences in out-of-home-care to create and facilitate positive change in the child welfare system. As DCYF's identified youth advocates for youth in the care of the Department, their mission is to raise awareness of youth indicated issues within the system, and to seek to empower, educate and promote youth voice and choice, using a youth to youth approach.

ASPIRE Initiative: Rhode Island's Jim Casey Youth Opportunities Initiative:

ASPIRE (Aligning Savings, Permanency, Information and Resources for Empowerment) works to increase the percentage and number of older youth who achieve permanency before aging out of care and improve the successful transition of youth in foster care to adulthood through the following strategies: develop opportunities for youth engagement; increase financial knowledge and stability; document results; identify and disseminate best practices, and galvanize public will and guiding policy to provide needed supports for youth. Participants receive up to 8 hours of financial education and at completion receive \$100 in seed money to assist them in opening an IDA savings account. Participants are assisted with setting savings goals and are matched dollar for dollar up to \$1,000 per year toward the purchase of an asset within the following categories: education, investment, health, housing, vehicle, insurance, credit building/debt reduction, microenterprise.

Since June 2014, ASPIRE participants have had the opportunity to participate in one-on-one financial coaching through the Supervitamin project helping youth work on their financial goals and move toward greater financial capability, inclusive of increasing their credit score and savings, reducing the use of predatory banking and increasing food security. As of May 24, 2017, there are 333 active participants in the ASPIRE Initiative with a total of 965 served since inception. A total of \$1,278,450.08 has been saved and matched for the purchase of 888 assets by 335 unduplicated participants.

Teen Grants:

Teen Grants provide grants of up to \$300 per 12-month period to young people ages 16-21 who are in DCYF-sponsored out-of-home care or who participate in the YESS Aftercare program. These grants allow teens and young adults to participate in “rites of passage” activities or purchase items that will enhance their self-esteem, promote their independence, and further develop their skills and knowledge. As of May 24, 2017 250 active participants have received a teen grant totaling \$71,834 in grants awarded.

Chafee Education and Training Voucher Program (ETV):

Rhode Island’s commitment to ensuring that foster care and former foster care youth have access to postsecondary educational opportunities continues to grow and expand. ETV funding can be used for any postsecondary educational and training program that is approved by the US Department of Education for Title IV student assistance programs with a cap of \$5,000 per student per academic year. Our DCYF Higher Education Grant Program funding, an annual allocation of \$200,000, can be used for full-time students attending one of Rhode Island’s three public higher education institutions, the University of Rhode Island (URI), Rhode Island College (RIC) and the Community College of Rhode Island (CCRI). In FFY 2017, twenty-four (24) students received state funds totaling \$105,823.00.

For the past three years, DCYF has provided each student with funds to cover 80% of their unmet need unless they were eligible for the ETV funds only and hit their \$5,000 annual federally mandated cap. For the 2016-2017, academic year, 187 youth applied for funding and, of those applicants, 50 youth attended school and received funding. This assistance totaled \$292,382.00 from all funds.

Employment and Vocational Services:

The CYS Program staff help to ensure youth have access to supports and services they need to be successful in career development and workforce readiness. Through several grants including *Works Wonders* and funding from the Governor’s Workforce Board, the RI Foundation, Bank of America and Citizens Bank, Works Wonders has been embedded as part of YESS. The E2 curriculum, one-on-one job coaching, work experiences, job shadows and informational interviews are provided to unemployed or underemployed participants in YESS aftercare. Thus far, 92 YESS participants have been served.

Harvest Kitchen Project:

The Harvest Kitchen Project is a 20-week culinary and job-readiness training program for youth. In the first 15 weeks’ youth learn basic culinary arts skills and receive industry certifications. Youth then participate in employment internships to further develop their job readiness and employable job skills for the next 5 weeks. High-quality preserved foods using ingredients sourced from local farmers are made in the Harvest Kitchen and sold at local stores, farmers markets and to wholesale customers.

In 2017, DCYF entered into a (18) eighteen-month contract with Farm Fresh RI, the vendor that oversees the day to day operation of the Harvest Kitchen. The contract provides stipends to the youth and allows the Harvest Kitchen to double the amount of youth served to (40) forty youth per year. The Harvest Kitchen Corner Store and Café have direct employment opportunities for graduates and increased training opportunities for youth in other areas such as marketing, customer service and sales, shipping and receiving to name a few. DCYF collaborated with the Office of

Rehabilitation in supporting the Harvest Kitchen program for foster care youth that have a disability which effects their ability to find and secure gainful employment.

The Division of Community Services and Behavioral Health (CSBH)

Community Services and Behavioral Health (CSBH) is responsible for ensuring that DCYF's responsibility for children's behavioral health is addressed. DCYF is charged with developing a continuum of care for children's behavioral health services that encourages the use of alternative psychiatric and other services to hospitalization and reviews the utilization of each service in order to better match services and programs to the needs of the children and families as well as continuously improve the quality of and access to services. <http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-72/42-72-5.2.HTM>

CSBH works collaboratively with community providers and other state organizations in developing a comprehensive system of care that ensures effective services are provided to children in the least restrictive environment possible to support child safety, permanency and wellbeing, and overall family functioning. CSBH assists children and families involved with DCYF to access an array of behavioral health and other services based on assessments and needs of the child. DCYF provides services and supports to children, youth and families not involved with the department.

During the past two years, this division has undergone some restructuring to improve the effectiveness of providing needed services to children, youth and families, including the provision of new and innovative community based services and supports. DCYF implemented a number of initiatives that included a greater focus on service monitoring and planning. The implementation of Expedited Permanency Meetings provides a way to facilitate and support care in family settings and the Director's Approval Process reviews and approves all requests for congregate care placements. Another major change occurred after DCYF's decision to terminate the contracts with the Family Care Networks and re-assume within the department the function of referrals for service and placements. In addition, DCYF expanded the array of community based services to include new evidence-based or promising practices. Overall, this reorganization has been evolving as part of DCYF's goal to reduce the misuse of congregate care in favor of appropriate family placements and community-based services.

DCYF then developed an extensive RFP (Request for Proposal) for solicitation for innovative, new services, including congregate care and home and community-based services. DCYF secured new service contracts for 122 services with over 35 provider agencies working with our children's behavioral health population. Thirty-four of the service contracts are for community-based services, which more than doubles the number of community based services available from 16 to 34. As part of the 34 community-based services, 12 are evidence-based programs and 2 are promising practices.

DCYF has developed a DCYF Service Provider Guide that is organized into four categories of service: home-based services, specialized foster care, residential group care services and independent living programs funded by DCYF. This guide has been developed to assist in the identification and understanding of the resources available for children and families served by DCYF by providing descriptions of the different services as well as best fit criteria, exclusionary criteria, and other relevant factors that would be helpful when considering services for children and families.

http://dispatch.dcyf.ri.gov/docs/ResourceGuide_2017.pdf DCYF held provider fairs across the state for DCYF staff, community providers and partners to learn about the new services array and how to access these services.

Because of these changes, the division underwent a major transformation in response to new responsibilities for referrals, placement and community services that necessitated the development of the following:

1. Implemented the Central Referral Unit (CRU)
2. Developed a new referral process
3. Developed the level of need assessment process
4. Confirmed the name of the division to reflect the work done in the community and with behavioral health
5. Provides monthly Child Adolescent Needs Strengths (CANS) assessment training
6. Tracks all service referrals, capacity and utilization of programs and services
7. Developed a new resource guide with information on all new services
8. Developing a Utilization Management unit

The CRU was designed to connect children to the right services at the right times on a pathway to permanency and to reduce the need for placement in out-of-home care. Children, youth and families are now being assessed for services using the Level of Need assessment. This tool, based on the CANS, helps by identifying and scoring various risk areas and behavioral health dimensions. This analysis allows for a more accurate matching of the child's needs to a placement or a community service.

Other functions of CSBH include providing oversight to ensure that the delivery of services to youth offenders and those who have been affected by sexual abuse meet the best practice standards. ***The Sexual Abuse Treatment for DCYF Involved Youth Practice Standards*** were developed by the Continuity of Care Group (CCG), a collaboration of sexual abuse treatment providers (residential and community based), DCYF staff, other public agencies and victims. These standards were promulgated in April 2014 and require providers, either individuals or agencies, to be approved to treat DCYF involved youth who have been sexually abused, have exhibited problem sexual behaviors or have been affected by sexual abuse.

CSBH provides certification for providers of mental health emergency services interventions to children and families that focus on clinicians being child and family competent and having adequate supervision. DCYF also tracks the mental health emergency services interventions provided throughout the state by all the Community Mental Health Organizations (CMHOs) and other certified mental health provider organizations.

DCYF has a separate licensing division which oversees and licenses all out of home placements providers including residential, group homes, foster homes, and day care facilities for children. All facilities' staff are required to be fingerprinted and to have a DCYF clearance to work with children and youth.

The Development of the System of Care for Children and Families for provision of behavioral health prevention, early identification, treatment and recovery support systems for children, youth and families

Since the 1990s, DCYF has been moving toward a single, integrated system of care (SOC) to provide individualized, family-focused, community-based and culturally appropriate services to children and families throughout the state. Initial steps toward this integrated system of care included the creation of regional Family Service Unit offices and a focus on community-based services. Along with this, DCYF developed a single information management system, the Rhode Island Children's Information System (RICHIST) that includes case management, staff management, financial management, provider management and policy and procedure management functionality. RICHIST also supports demographic, behavioral, medical and legal

data collection and a range of continuous quality improvement tasks. During this time, DCYF received multiple grants to assist in moving toward a system of care that focuses on family centered planning and community based services as an alternative to more restrictive interventions for children and youth. These grants assisted DCYF in the transformation and development of a system of care by first developing the Family Care Community Partnerships (FCCPs) to address the front-end needs of the child welfare and children's behavioral health systems (January 2009). The FCCPs became a significant referral resource for the CPS and Intake divisions of DCYF to link families with necessary supports and services without removing children from the home. The FCCPs represent the Department's implementation of a differential response for family situations that do not warrant legal status involvement with DCYF but could benefit from community-based services and supports. The FCCP program is also available to families not involved with DCYF through a community or self-referral.

The SAMHSA grant, the RI System of Care Expansion-Implementation Cooperative Agreement has been able to provide guidance to DCYF's continued development of the system of care. The goals developed by this grant are:

Goal 1-Develop across-agency infrastructure with the resources and operational capacity to coordinate the SOC for children and youth with SED and their families.

The RI Children's Cabinet has become the across-agency infrastructure with an interagency governance board committed to cross agency communication and coordination to improve service delivery for children, youth, and young adults with behavioral health needs and who are at risk or involved with child welfare. DCYF had originally addressed the need for a system change that would improve the community based service array and reduce the unnecessary reliance on congregate care through a redesign of the system through the creation of the Family Care Networks (FCN). The FCN was in existence for over three years but was unable to manage the goals of the program and the cost and number of children and youth in out of home care increased during that time. A thorough review and analysis of the system resulted in discontinuing the networks and using the lessons learned as the foundation for the restructuring of the functions of the networks that were resumed by DCYF.

In 2016 Governor Gina Raimondo reconvened the Rhode Island Children's Cabinet. This is a group of high level state department directors that meet monthly to work toward implementing policies and programs to better meet the needs of Rhode Island's most vulnerable children. The Children's Cabinet is able to view the large scale system of care that is attentive to the needs of children, youth and families in all arenas. This process ensures a commitment for all state agencies to work collaboratively in leveraging all work being done in the state. This has resulted in more coordination and joint projects to benefit children in addition to the many grants and initiatives that required state agencies to work together on addressing the needs of children, youth and families. The state continues to work on the planning and implementation of the Center for Medicaid Services (CMS) State Innovation Model (SIM) grant focused on healthcare redesign and continues to ensure strong input on the behavioral health needs of children, youth, and young adults and their families. The Children's Cabinet has developed a work plan of services to address children and youth in all areas of their lives.

<http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-72.5/42-72.5-2.HTM> Children's Cabinet goals

Goal 2- Develop and sustain a comprehensive array of mental health and recovery support services for children and youth with SED and their families across service systems which are delivered by a well prepared, responsive and diverse workforce.

Over the past 2 years, the DCYF has engaged a wide range of community partners, national experts, technical advisors, and other stakeholders to solicit input on its strategy to achieve better results for the

children, youth, and families in its care. This review led to the DCYF's decision to return all placement functions back to DCYF from the two Networks of Care. This announcement was made in December 2015 and the Networks were formally ended in March 2016.

In March 2016, the Rhode Island Department of Administration/Division of Purchases, on behalf of the Rhode Island Department of Children, Youth and Families (DCYF), issued a request for proposals (RFP) This RFP solicited home and community-based services to help families in DCYF care safely remain together, facilitate and sustain family reunification, and improve anti-social behaviors and strengthen court compliance of delinquent youth. Placement-based services for children, youth, and families who require effective clinical treatment in a safe environment before returning to a family like setting were also included in this solicitation along with integrated proposals that bridge target populations and outcomes inclusive of both home- and placement-based services.

With this procurement, the DCFY was able to enhance and expand services, supports, and resources that have a high likelihood of improving the safety, permanency, and well-being for children and families served. Innovation new services were added to the service array. DCYF resumed the functions of the network and developed a new process to address and enhance the delivery of services. CSBH was re-organized to resume the responsibility of processing all new congregate care and community-based service referrals through the newly developed Central Referral Unit (CRU).

Goal 3- The State's system of care- at every level and in every setting-is driven and guided by the diverse children, youth and families that it serves.

RI has a very diverse population. DCYF has initiated or improved systems to address the issues and concerns of a diverse population through their involvement in the process. One example of this is DCYF partnership with the Parent Support Network of Rhode Island (PSN-RI), our statewide family organization for children, youth and young adults with behavioral health (mental health and substance use) and their families to engage in system of care and grant activities. Some of the activities addressing youth voice and choice and involvement in care include:

Youth-Young Adult Leadership & Involvement

- Weekly Youth Speaking Out (YSO) group meetings with youth with behavioral health needs between the ages of 13 to 18 years old
- Youth MOVE RI activities where YSO youth leaders facilitate and assist in projects concerning youth and young adult substance use
- Youth MOVE RI Leadership Team has monthly planning meetings for work on joint activities, such as brochure and Recovery Rally table and youth and young adult activities
- Peer support for helping parents
- LEAD-Fatherhood Initiative:
Implementation of the Leadership, Equality, and Advocacy for Dad's (LEAD). LEAD is now holding monthly father leadership and support meetings

Goal 4- Strategic communication and social marketing increase support among families/youth, public and private providers and shapers of public opinion.

DCYF communications staff continue to partner with state and local agency partners to promote state and local child abuse prevention and children's mental health awareness campaign activities throughout the

year. DCYF worked collaboratively with the FCCPs and the Parent Support Network and other community partners to provide various activities statewide for the Mental Health Association's May is Mental Health month events.

DCYF has supported and encouraged the development of a community based system that can provide strong prevention-focused support programs to assist in diverting families from DCYF involvement, when appropriate. With this approach, a much greater emphasis is being placed on community-based family support and services that embrace the positive wraparound values and principles of a system of care which focuses on wellness and community with less reliance on and reduction in out of home placements in residential programs. Federally funded programs and grants have complemented the DCYF's continuum, which include prevention and early intervention programming for family preservation and support and substitute care living arrangements with relatives, kinship, and non-relatives. DCYF's system of care transformation has required the development of a responsive continuum of community behavioral health services and supports in each region of the state for children with serious emotional disturbance and their families. The goal is to enhance the system's ability to provide increased access to community-based services and natural supports that are strength based, family driven, youth guided, culturally and linguistically competent, and that promote the family's self-efficacy.

As with any system change DCYF has had the opportunity to make decisions and improve its current practices based on the lessons learned. DCYF has been successful in the transformation of services through other federal initiatives such as the Community-Based Child Abuse Prevention (CBCAP) program. DCYF has integrated the work of the Family Care Community Partnerships (FCCPs) to engage a statewide network of primary, secondary and tertiary child abuse and neglect prevention programs.

CANS

As part of the system development and to assist in evaluating the strengths and needs of children and youth, DCYF has implemented the use of the Child and Adolescent Needs and Strengths (CANS), a standardized, nationally validated functional assessment that includes a separate modular on trauma. Children and youth who enter residential care and specialized foster care are assessed using the CANS and reassessed quarterly and when they are discharged from placement. Results of the CANS is entered into a Web Portal and is used to inform the assessment and the develop of the treatment plan. The child-specific information from the CANS is available for the worker to review and also for DCYF use for research and analysis to improve practice. This data was used to develop the Level of Need Assessment used in the CRU process with additional information being imported to the Web based portal.

Monthly certification training is provided for community staff and DCYF staff. All staff using the CANS are required to complete a yearly re-certification. The CANS is used by community providers for other services.

Rhode Island Child Welfare-Early Care Partnership

DCYF secured funding for the Rhode Island Child Welfare-Early Care Partnership (2012) "to secure an infrastructure across early care systems to ensure that infants and young children in the child welfare system receives quality early care and education services which ameliorate the effects of exposure to trauma and improve their social and emotional well-being to better address barriers to permanency.

DCYF Early Childhood Initiatives

Building on the work of the Rhode Island Child Welfare-Early Care Partnership, RI DCYF has continued to develop an integrated system of care to meet the needs of young children birth to 5 years old in the

child welfare system. These efforts have focused on three primary areas: developmental screening and evaluation for children identified as victims of abuse/neglect, referral to federally funded MIECHV (Maternal Infant Early Childhood Home Visiting) Family Visiting programs and promotion/ access to high quality early care and education programs. RI DCYF has worked to strengthen cross system policies and processes to ensure that all children birth to three identified as victims in cases of abuse neglect are referred to the Part C early intervention system. These efforts have resulted in a consistent increase in the rate of referral over the past several years. Beginning in 2014 with a referral rate of approximately 60 % the department has increased the referral rate to 63% in 2015 and 65.5 % in 2016. The most recent revision in policy has resulted in a 95% referral rate for the month of June 2017. DCYF anticipates that this rate of referral will be sustainable and will begin to focus on tracking rates of engagement for this population. DCYF has also revised data sharing and tracking systems that will increase the rate of Child Outreach Screening for children 3 to 5 years old in the foster care system. Over the next year baseline data will be gathered and targets will be set to improve access to these critical developmental and social emotional supports.

RI DCYF has utilized existing resources to continue to promote and refer families with young children to federally funded Family Visiting programs. Since 2014 RI DCYF has consistently increased the rate of referral to these evidenced based programs. Referrals for the past several years are as follows: 52 in 2014, 85 in 2015 and 93 in 2016. This increased rate of referral has provided families with a long term program that can continue long after the family's involvement in the child welfare system ends. These evidence based programs provide developmental and parent-child attachment supports that help families develop and maintain healthy relationships that serve as a strong foundation for future mental health and well-being.

DCYF has also continued to support access to High Quality Early Care programs for children in the child welfare system. This process has included promotion of High-Quality Early Care with foster parents who accept placement of children under age 5 and targeted referral to Head Start and State Pre-K programs. These efforts are designed to provide children and families education and social emotional supports that will help support future success in their schools and communities. Over the next year DCYF will work to develop data systems that will track DCYF involved children enrolled in High-Quality Early Care settings with a goal of increasing access for this target population.

As a part of the Children's Cabinet work, an initiative called Getting to Kindergarten was established. This initiative focuses on the well-being of young children in the child welfare system. To date a set of goals and a work plan have been developed to begin this work. Staff from DCYF and the RI Department of Health have continued monthly meetings to look at referral and response to referral issues for children subject to Federal mandate. Quarterly review will continue to allow for more timely strategic planning and system improvements to be implemented for this high risk population. All of the above stated efforts will be integrated over the next year into the Children's Cabinet Initiative titled the Birth to 3rd Grade Reading Plan. This plan will work to have a positive impact on the youngest and most vulnerable children in the state in order to dramatically increase the rate of reading proficiently for 3rd grade students by 2025. Ongoing training and support of DCYF and community staff will ensure that all children subject to an indicated incident of neglect or abuse are referred for screening or evaluation within the early intervention system.

In March 2017 the updated Early Childhood Service Referral Policy was approved by DCYF's new Director Trista Piccola. This policy revision and implementation is the culmination of 18 months of work at the system

and policy level to improve the rate and fidelity of referrals for the birth to 3 population involved in the child welfare system. Grant staff guided revision of the RICLIST system to support the policy change and trained all CPS staff on implementation of the new process. This system improvement will net a nearly 100% referral rate for children birth to 3 identified in substantiated cases of abuse/neglect. Over the next year DCYF will work with other state partners to track the rate of engagement of the children and families referred. This work has been done in collaboration with the statewide EI/ Child Welfare Workgroup in order to include input by all stakeholders involved in the process.

As part of RI DCYF's overall early childhood system of care development, DCYF has submitted a grant request proposal to the W.K. Kellogg Foundation of Battle Creek, Michigan titled "Rhode Island Child Welfare-Getting to Kindergarten Initiative." The focus of this proposal is to build on and expand the DCYF's capacity to focus on the developmental and social emotional well-being of young children in the child welfare system.

Neo-Natal Abstinence Syndrome Task Force

The Neonatal Abstinence Syndrome Task Force was developed as a part of the Governor's Task Force on Drug Overdose. With the rates of opiate abuse on the rise both nationally and here in Rhode Island the NAS Task Force has worked over the past 2 ½ years to build interagency collaboration to better meet the needs of substance exposed newborns both in and out of the child welfare system. This task force has engaged stakeholders from a broad range of community providers and state agencies to systematically address this issue. These stakeholders include representatives from Dept. of Health, DCYF, Medically Assisted Treatment providers, OBGYN Practices, Birthing Hospitals, BHDDH (state agency responsible for adult substance abuse treatment and addiction recovery supports) and other Home Visiting and Early Childhood providers. The Task Force has developed three specific workgroups to focus on prenatal referral and supports, hospital protocols, training for community providers and in 2017 will likely form a subcommittee with a specific focus on NAS babies in the Rhode Island child welfare system. This task force will continue to be active in its work over the next year and seek to strengthen interagency collaboration to support this population. DCYF will continue to actively participate in the planning and implementation of this groups work. DCYF will also make changes to data collection processes in RICLIST system to better track substance exposed newborns and specifically infants diagnosed with NAS. This will allow for better tracking of needs and services referral processes for this critical population. DCYF is also working with state agency partners and birthing hospitals to implement a structure for Safe Plans of Care for Substance Exposed Newborns. This cross-system work will ensure that newborns and their families will have consistent plans of care for access to supportive services upon discharge from birthing hospitals in Rhode Island.

Addressing the Needs of Diverse Social, Ethnic and Sexual Gender Minorities in the System of Care

DCYF continually addresses the access to services, service delivery, personnel makeup, training, practice standards and contracts to ensure that the needs of diverse social, ethnic and sexual gendered minorities are being met. Requirements in contracts reflect the need for staffing to be diverse and meet the needs of children, youth and families. Service providers must be able to meet the needs of the clients including meeting the Culturally and Linguistically Appropriate Services (CLAS) standards.

There is a disproportionality higher number of Black or African American, Multiracial and Hispanic children entering out of home placement, especially in the age group of 10-17year old.

http://www.dcyf.ri.gov/docs/reports/DRAFT_FY13-16_permanency_entry_cohortv4final.pdf DCYF Permanency Report, July 1, 2012 – June 30, 2016.

Based on current research, it is estimated that about 20% of youth in out of home care identify as LBGTQQI which is twice the percentage in the general youth population. At present, DCYF is not able to collect this information; one provider of services, Youth Pride provided services to 840 youth overall in 2016; 15 % - 126 of these youth reported DCYF involvement. DCYF now has increased its specialized services through the re-procurement process for support services for foster and kin families caring for a child with diverse sexual orientation, gender identity, expression (SOGIE). There are also new clinical and community based services for LBGTQQI youth including an independent living program. DCYF has implemented a new policy on the treatment of youth with diverse SOGIE in out of home placement. DCYF has a children's bill of rights and policies on confidentiality to protect youth dealing with "coming out" issues.

A LBGTQQI committee comprised of members from DCYF, community providers, other state agencies, gay and lesbian advocates, Public Defenders and Youth Pride, Inc worked collaboratively in the development and implementation of DCYF's SOGIE policy. A three-day training was developed to cover adolescent identity development, legal responsibilities and practice recommendations as well as a one-day training for all new staff to DCYF. Guidance on working with transgendered youth is currently being addressed by this committee.

DCYF has an internal charter that addresses diversity issues with staff and families serviced by DCYF. The Diversity Council recognizing the critical importance that diversity of thought, related to dissimilar backgrounds and experiences, plays in the delivery of services to our children, youth and families. The mission and role of the council is to guide DCYF on developing organizational changes and strategies that will advance the goals of diversity and inclusion in the workplace.

Next Steps in transformation and system development

DCYF continues to work collaboratively with other state and community agencies to address areas of need that affect the safety, permanency and well-being of children, youth and families not only in DCYF care but in the community at large. DCYF is actively working on numerous collaborative projects that address a statewide need for system change. DCYF systems-level efforts are addressing several of the goals of the RI Medicaid program of maintaining and expanding on the state's record of excellence in delivering care to children and the goal of shifting Medicaid expenditure from high-cost institutional setting to community-based settings. These changes are in line with recommendations of the Truven report on the need for greater emphasis on investments in proven, effective preventive services and supports and providing more evidence-based services in a community setting in collaboration with other community organizations.

Examples of this system work include areas like neo-natal abstinence syndrome, early childhood initiatives, safe sleeping, preventing child abuse, domestic violence, homelessness, and commercial sexual exploitation of children to mention just a few. Inclusive and transparent collaborations allow for the transformation of how services are delivered and the importance and necessity of working together to develop more successful outcomes. The re-procurement and expansion of community based services reflects these goals and recommendations. By realizing that the previous process of contracts for services was not resulting in the expected outcomes, DCYF took a major step forward in developing a different type of relationship with the community providers that has the potential of producing better results for children and families. DCYF is working on transforming the relationships with community providers through an active contract management process that focuses more on outcomes and accountability.

The community providers are also working more collaboratively with each other. For example, the Rhode Island Coalition for Children and Families which represents a number of providers of community based services and residential programs with similar values advocated for the extension of care for DCYF youth. This extension would provide valuable resources and supports to youth from age 18 to 21 by being able to stay in their out of home care while preparing for transition to adulthood. Research shows that this population has better long term outcomes as a result. Although this legislative act has not passed, there is community support for providing additional support and services to DCYF transitioning youth to the adult system.

DCYF has an Interagency Agreement (ISA) with Executive Office of Health & Human Services, the single state agency duly authorized by the Centers for Medicare and Medicaid Services to administer the Medicaid program and has delegate specific elements of its authority and responsibility to DCYF in the agreement. This agreement governs participation by DCYF in the RI Medicaid Program and the ability of DCYF to access federal funding. Funding for services is based on contract negotiations and conditions specified in the agreement. Work is being done to move toward community providers being able to direct bill for services they provide; this is being supported and encouraged by EOHHS the state's Medicaid authority. In order to do so, DCYF is working on developing a process that would result in providers being able to direct bill.

At this time, some services provided by DCYF are not available to children and youth unless they are opened to DCYF. DCYF is working on a process to provide behavioral health service to children and youth who are seeking help from the DCYF due solely on service need. DCYF is looking at ways that children and families not open to DCYF can receive the necessary services that will help prevent the development of a serious emotional disturbance. DCYF is working with the Family Court to put a plan in place for families who need access to behavioral healthcare services prior to the Family Court ordering children into the care of DCYF.

Improving the collaboration and integration of services for youth transiting to the adult system. Currently DCYF is working with BHDDH on services for youth and on reviewing the existing process of transitioning youth with DD or SED to the adult system.

DCYF is continuing to monitor the number of children in care and evaluate their needs using information obtained from the CANS. Reducing the misuse of congregate care in favor of appropriate family placements and community-based services is one of the goals of the active contract management process.. There has been ongoing success achieving a 25% reduction thus far. However, as of August 2017, 45% of the children entering congregate care settings would be better served in a family setting. In order to change this, DCYF needs to have families who can care for these children and who have the services necessary to keep them stable and support their success. Some of the strategies that are being implemented include the following:

- New home-based services including supports for DCYF foster and kinship families.
- Meetings with providers of family-based foster care about recruitment, development and support.
- Community Services and Behavioral Health Division working closely with the Family Court to put a process in place for families who need access to behavioral healthcare services prior to the Family Court ordering children into our care.
- Utilization of the Director's Approval Process (DAP) as an appropriate gatekeeping mechanism to ensure children are not entering congregate care who should not be there.

- Utilization of the Expedited Permanency Meetings (EPMs) as a comprehensive review process to ensure children who have been waiting for permanency with a family receive the services and supports they need immediately.

DCYF anticipates issuing additional procurements over the coming year, including solicitations of services to prevent crisis-driven disruptions in care through mobile crisis response; services to support successful transitions to adulthood for current and former DCYF youth; services that accelerate and sustain adoption or guardianship when reunification is not an option; and services to divert youth from the juvenile justice system, such as those provided through Wayward/Disobedient programs and Youth Diversionary Programs.

Treatment Services Available in the System of Care for Children

Medicaid Coverage for Services to Meet the Mental Health Needs of Children, Youth and Families

According to Child Welfare League of America, 99,712 children in Rhode Island were enrolled in Medicaid in 2015. During 2014, 6099 children under age 18 were treated at CMHCs. 24% of these children had a primary diagnosis of attention deficit disorder, 22% had depressive – related disorders, 16% had anxiety disorders and 13% had conduct disorders (RI KIDS COUNT *Factbook*).

Treatment options available through Medicaid and health insurance include outpatient individual, family and group therapy; intensive home-based services; respite services; behavior management; psychiatric assessment; and treatment, including medication management, psychological assessment, inpatient services and sexual and substance abuse treatment. Community Mental Health Centers (CMHC) have Children's Services Program administered by a children's services coordinator, and provides a range of services that include emergency service, outpatient services, and intensive home-based treatment. In addition to the above services and programs, day hospital services targeted for children and adolescents with severe behavioral, developmental, and emotional disorders are available at nonprofit child and adolescent psychiatric hospitals. Local school departments administer day programs for behaviorally disordered children and adolescents that are available to out-of-district youth.

The insurer for health and mental health/behavioral health services for children in DCYF care in out-of-home placement is Neighborhood Health Plan of RI (NHPRI-Beacon Healthcare Strategies). Child/youth has dental coverage through RI Smiles. DCYF in partnership with the state Medicaid agency, the Executive Office of Health and Human Services (EOHHS), provide access to health insurance coverage by automatically enrolling children and youth entering out of home placement. When the youth is aging out of foster care, DCYF automatically enrolls the youth in the Post Foster Care Medicaid Coverage Group (“Chafee Medicaid”) which under the Affordable Care Act (ACA) extended this Medicaid coverage to youth until the youth’s 26th birthday. DCYF also provided extended RiteCare medical coverage to parents to support reunification efforts.

Services Available through Medicaid and Insurances

Inpatient Psychiatric Services

State funded inpatient psychiatric services for children and adolescents are provided by three private nonprofit hospitals. All publicly funded children are served by their Rite Care managed care providers.

Acute Residential Treatment Services (ARTS):

ARTS is a short term acute psychiatric hospital step-down or diversionary program. These programs have complete diagnosis and assessment capabilities with psychiatric and nursing

services funded by health insurance or Medicaid. This service provides short-term stabilization and treatment necessary to prevent re-hospitalization or long-term residential treatment.

Enhanced Outpatient Services (EOS):

EOS is a short-term, intensive program that provides clinical (counseling) and family support services to children up to age 21 with moderate to severe emotional and behavioral disturbances. It is funded through insurance or Medicaid. The goal of EOS is to stabilize children's functioning to prevent unnecessary psychiatric hospitalization or residential treatment. Services are family-centered and scheduling is flexible with services usually delivered in home and community settings. With the incorporation of EOS into the managed care contract as an in-plan service, this program has become more closely integrated with other intervention options in the health plans' full spectrum of behavioral health services. Many evidence based practices are now provided as part of the Enhanced Outpatient Services (EOS) that is covered through NHPRI-Beacon Healthcare Strategies.

Emergency Services Hotline and Mental Health Emergency Interventions for Children:

There are ten provider agencies of Mental Health Emergency Interventions for Children. Each has a hotline that is confidential and free to families who will receive a call back within 15 minutes, and, if needed, a face to face assessment within two hours with a child competent clinician who can assess the situation and assist families toward the least restrictive option for appropriate care.

Treatment Services Available through the DCYF

Currently, DCYF provides a range of out of home services including residential treatment programs, residential counseling centers, group home and other out of home placements for children and youth. DCYF has developed a new process for making referrals based on the child or youth's needs. This new system is based on referrals going through the CRU who processes all congregate care, specialized foster care, DCYF foster care and home-based service referrals. Based on the census received weekly, the CRU is able to track the use of each specific service and placement based on capacity of all the placements and community based services to ensure that children and families receive services timely and receive the right service to meet their needs. As part of the development of the CRU, the programs and services have been reviewed and re-grouped according to type and use of service. The following are the updated descriptions for out of home placements:

Assessment and Stabilization:

There are 6 Assessment and Stabilization placements with the capacity of 50 slots available across the state for children and youth from birth to eighteen years of age. These are temporary placements that provide both social and mental health services to children and youth.

Adolescent Male:

There are 11 group homes that provide placement for adolescent males in a community –based facility that utilizes local schools and recreational and cultural services. Intensive mental health services are available and include a clinical level of service that is part of DCYF's hospital diversion and step down programming. The 11 group homes have a capacity of 79 youth.

Adolescent Female:

There are 7 group homes that provide placement for female youth in a community –based facility that utilizes local schools and recreational and cultural services. Intensive mental health services are available and include a clinical level of service that is part of DCYF's hospital diversion and step down programming. The capacity of the 7 group homes is 56.

Under 14 Group Homes:

There are 3 group home with a capacity of 21 children.

RTC (Residential Treatment Center): These residential treatment programs are long term sub-acute psychiatric step down programs. RTCs are self-contained campus settings that provide an intensive level of casework, therapy and educational programs and provide services for youth with SED or at risk for SED. There are 8 programs with a capacity of 127.

Problem Sexual Behavior (PSB) Group Homes:

There are 3 specialized group home programs that provide a structured treatment milieu as an alternative to residential treatment for youth who have sexually abused in a community based program. These programs utilize a fulltime clinician and provide special treatment approaches for sexually reactive/offender youth and intensively supervised daily programs in the home, school, and community setting. The capacity of the 3 group homes is 22.

Developmental Disabilities:

There are 4 specialized group home programs for this special population with a capacity of 22. These homes are for children and youth with developmental disorders who require a structured treatment milieu. These programs are designed as an alternative to residential treatment and/or to meet the needs of children and youth who are discharged from residential treatment programs.

Semi-Independent:

There are 12 specialized programs for semi-independent with a capacity of 74 youth. Supervised apartment programs help to transition adolescents ages 16 and older to independent living. In-house supervision is provided twenty-four (24) hours per day with sleep-in staff. Youth are routinely allowed unsupervised time in the community to attend school, jobs, and for recreational and social activities.

Independent Living:

Independent Living Programs offer youth the opportunity to live in their own apartment with staff assisting with educational, vocational and employment needs and independent living skills. The youth receive on-going education and support to prepare them to successfully live independently. Capacity of 34 apartments available across the state.

Therapeutic Foster Care:

Specialized foster care programs provide professional support services to children, youth and foster parents. Individualized treatment is provided within a supportive and structured home environment. These programs help to foster positive relationship skills, ameliorate emotional conflicts related to attachment and development, and prepare youth for transition to home, long term foster care, adoption, adult living or other age and developmentally appropriate settings. In FY 2017, the average daily number of children and youth in a therapeutic foster care placement was 278. In the last few months (May, June) there has been an increase to 323 in May and 336 children in June reflecting progress in efforts to increase use of foster care. DCYF is aiming to increase use of foster care and to continue to reduce the unnecessary use of congregate care placement.

Specialized foster care provides professional support services to children, youth and foster parents. Individualized treatment is provided within a supportive and structured home environment. These programs help to foster positive relationship skills, amelioration of emotional conflicts of attachment and development, and prepare youth for transition to home, independent living or other age and

developmentally appropriate settings. Treatment foster care provides more intense professional support services. Some of these homes may provide emergency placement for children.

Other Clinical and Prevention Services through DCYF

Diagnostic Assessment Service (DAS):

DCYF oversees and funds the Diagnostic Assessment Service program which is targeted for youth, age 12 to 18 referred by family court and truancy court who require intensive diagnostic assessment to determine appropriate case planning. Outpatient DAS allows youth to remain at home while being evaluated. The outpatient DAS reports are completed within three weeks of assignment. DAS reports are comprised of a psychosocial history and educational reports including educational testing and psychological evaluations with IQ testing. Based on this comprehensive assessment, a set of treatment recommendations are developed to guide the court's disposition on a youth. During the past calendar year, the number of DAS completed was 47 which represent a significant decrease over the past year in this area, due in part to services available through the court system and an increase in the array of services through DCYF.

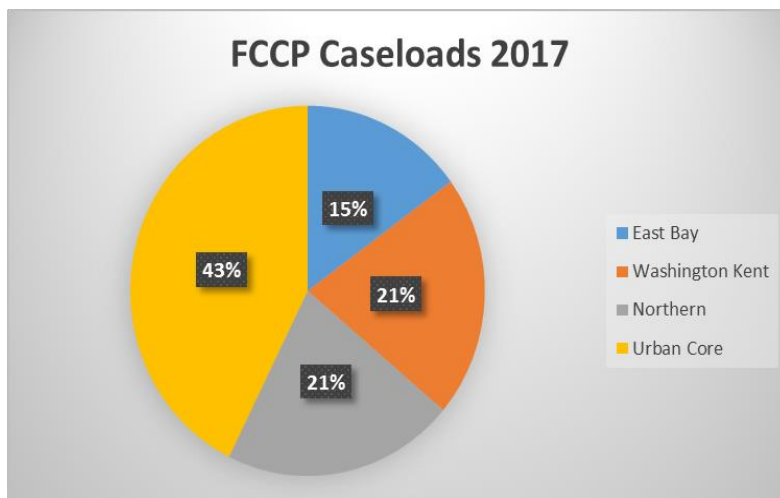
Evidence Based Practices, Evidence Informed, Community Based Services:

As a result of the large scale re-procurement in FY 2017, DCYF increased the number and type of evidence based, evidence informed and promising practices demonstrably for both community based and congregate care settings. There are now 31 home and community services that can be accessed through the CRU. This results in having 1195 available slots for service. As of August 2, 2017, 75% of the slots were full, not counting the pending cases. Some of these community based programs include Trauma System Therapy, Positive Parenting Program (Triple P), Teen Assertive Community Treatment (TACT), and Multi-Systemic Therapy (MST) and MST-PSB. Both FCT and TST have residential programs that engage family while youth is still in their placement setting with the goal of supporting and preparing families for reunification.

In DCYF's guide, these services that are home-based are organized based on the California Evidence-Based Clearinghouse for Child Welfare; these include the following 8 types of service: Supervised Visitation Services, Foster and Kinship Care Supportive Services, Family Stabilization Programs, Disruptive Behavior Management, Mental Health Treatment Services, Parent Training and Skill Building Programs, Specialty Populations and Services, Miscellaneous, and Direct Referrals.

Family Care Community Partnerships (FCCP):

The primary focus of the FCCPs is to improve the lives of children and families, not open to DCYF, through prevention and the provision of effective community-based services and supports using a wraparound planning model to avert children, including those with SED or at risk of SED, and their families from becoming involved with DCYF. Services are provided through one of four designated geographic regions. The largest FCCP covers the urban areas of RI consisting of Providence, Pawtucket, Central Falls and Cranston whose population is among the most diverse, poorest and most underserved in the state. The other three FCCPs cover the east section, the northern section, and the southern part of RI.



Family Care Community Partnerships provide:

- ☐ *Family stabilization*
- ☐ *Engagement and facilitation of wraparound planning teams.*
- ☐ *Comprehensive Care Coordination*
- ☐ *Home-based support and behavioral health interventions*
- ☐ *Intensive family support, coordination and brokerage of services and supports*
- ☐ *Linkage to other community supports and services*

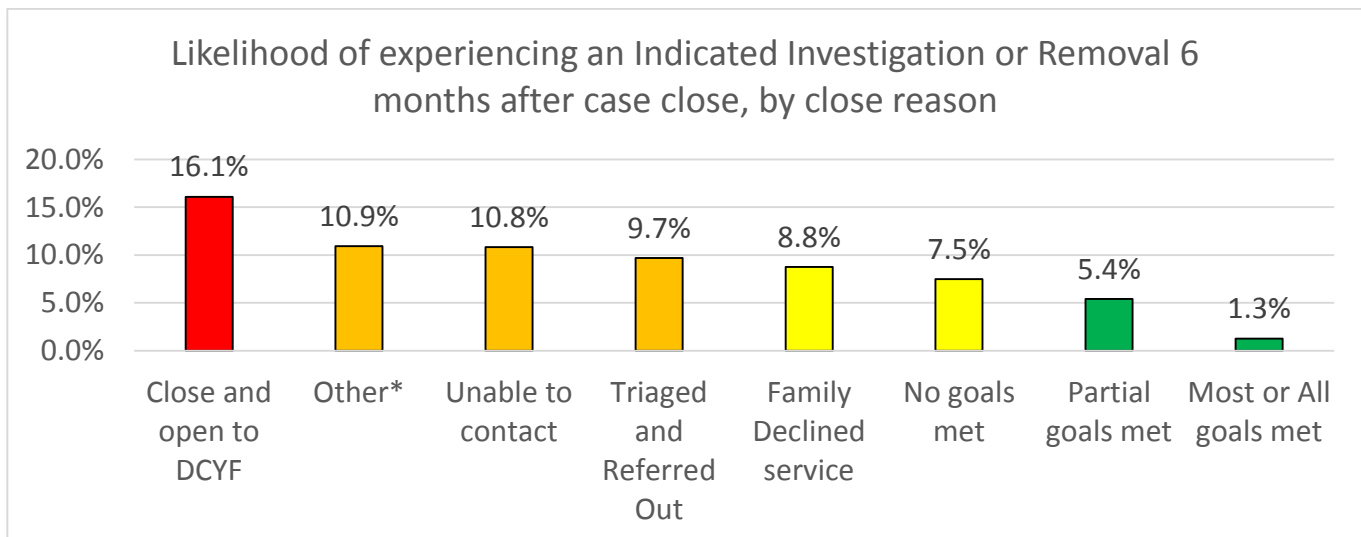
To support the FCCPs, DCYF

implemented the Rhode Island Family Information System (RIFIS), a web based data information system designed to support the collaborative work of families and providers in the FCCPs. RIFIS captures data and outcomes to assist each stakeholder in the system with better management tools to assess effectiveness. Monthly, quarterly, semi-annual and annual reports are produced to reflect on outcomes, compliance and system improvement as part of an Active Contract Management process. The FCCP provide necessary community based support and wraparound services for children and families who are at risk for DCYF involvement for child maltreatment; children who are mentally, emotionally, and behaviorally challenged; or youth who are involved with juvenile corrections. Community organizations such as schools and mental health organizations or the family can make a referral to the regional FCCP requesting services. Each regional FCCP provides community education focused on prevention and wellness at least once a year. The number of families receiving services through the FCCP is as follows:

An estimated 20% of the children receiving services through the FCCP are children with SED Community referrals and self referrals to the program focus on families needing multiple services with children at risk or diagnosed with SED. Those children referred by DCYF to the FCCP are those at risk of further DCYF involvement, residential care, trauma through domestic abuse in the home and neighborhood, and involvement in the juvenile court system. Many families seek help due to homelessness and lack of support to provide for their children. Most of the children live in the four core cities in the state. Project Early Start services are available through the FCCPs; these in-home services to families with children birth through five years of age that include care management, nutrition counseling, child development/education, parent aides and recreational activities.

FCCP	FY 2014	FY 2015	FY 2016	FY 2017
Total families served	1867	1700	1550	1626
# Referred to FCCP by CPS or Intake	1141	1020	887	827
# Community and self-referrals to FCCP	726	680	663	799
Source: RIFIS, Total primary child's RIFIS IDs# =families served				

Through active contract management process, DCYF has been able to analyze the data and track outcomes; families who stay open to the FCCP and meet some or most of their goals do not experience an indicated investigation or removal in the six months after the case closes.



Other Community Prevention:

DCYF also administers several programs and services through other federal funding. These federal programs all align in a continuum of care and service to support and help guide the efforts to protect the most vulnerable population of children and to promote family strengths and healthy functioning. The Safe Families Collaboration Program with the Coalition Against Domestic Violence provide Domestic Violence liaisons that are co-located at DCYF and at the four FCCPs to provide families the support, consultation and advocacy necessary to address issues of domestic violence. Other prevention services include educational outreach and advocacy to prevent child abuse.

Differentiate between child and adult systems:

DCYF works under the umbrella of the Executive Office of Health and Human Services (EOHHS) to provide services to children, youth and families and is responsible for the oversight of all children's behavioral health services. DCYF provides services to youth to age 18 and for those youth with serious behavioral health or DD until age 21. BHDDH provides behavioral health services to the adult population starting at age 18 and substance use services to youth and adults. The Department of Health provides services to young children through a variety of home visiting programs. The sister agencies of DCYF- BHDDH, DOH, and DHS (Department of Human Services) work together with the support of the Executive Office of Health and Human Services (EOHHS) to provide a variety of services to address poverty issues through enhanced child care subsidies, collaborative efforts to provide workforce development training and improve employment outcomes and to address ways to improve communication and coordination of the referral process and services to children and families.

DCYF has worked collaboratively with the other state agencies on various different programs and projects concerning children's behavioral health. Of special note is the work being done with BHDDH around transitioning youth from the child system to the adult system and with the Department of Health concerning early childhood services, safe sleeping campaign and drug exposed infants.

Transitioning youth

Transitioning youth has been determined to be area needing special attention. Currently the age when DCYF care ends is 18 or 21 if youth has a developmental disability or mental health/behavioral health condition that warrants the extended stay. DCYF has been working internally on developing systems to address transitioning youth as part of a Federal mandate. DCYF has secured additional services through

the recent re-procurement of services to address some of the specific issues of youth with serious emotional disturbance. A few years ago a sub-group of the Governor's Council tackled this subject and produced a report that was presented to the Governor's Council. During the past two years there has been more focus concerning the needs of youth transitioning to adulthood in part due to several factors. BHDDH received two grants that focus on this age group, the Healthy Transition grant and the State Youth Treatment (SYT) implementation grant. The focus of the grant is on improvement of existing state infrastructure and the provision of direct treatment for SUD and /or co-occurring substance use and mental disorders and recovery support services.

DCYF has a number of programs and services to help youth transition to adulthood as noted in the previous section on Consolidated Youth Services for youth age 16 to 21. A recent work group is looking at the process for referrals from DCYF to adult services provided by BHDDH. As of July 17, 2017, there were 117 youth age 18 to 21 in DCYF out of home care. During the last year, there were 72 referrals to BHDDH and 6 referrals for both BH and DD.

Special Population: Commercial Sexual Exploitation of Children (CSEC)

In January 2016, the Governor created the Rhode Island Human Trafficking Task Force, a collaboration of federal, state and local law enforcement agencies, the USAO and the RIAG who are dedicated to targeting and prosecuting offenders, dismantling human trafficking rings, and rescuing children and adult victims of human trafficking. The DCYF Special Investigations Unit (SIU) was created in July 2015, based on results from the initial assessment by the Strategy Team and outside experts.

On daily average, DCYF has 22 youth absent from care without official permission, half of these are from probation and none are missing more than a month or two without being located. DCYF is in the process of implementing policies, procedures and initiatives to verify, account for, prevent and locate these absent children. The Department classifies a victim up to the age of 18 and 21 if that youth is open to the Department or has a Serious Emotional Disorder or Developmental Delay.

As of June 2017, the Special Investigations Unit has reduced the daily average number of absent children to 18-22. Through coordination with law enforcement, Hasbro Hospital, Day One and others, we have confirmed (69) child victims of sex trafficking within the State. Of those, (42) are/were in DCYF care. DCYF has made significant progress using a whole community approach to prevent, educate and treat CSEC victims

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 programming.

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.

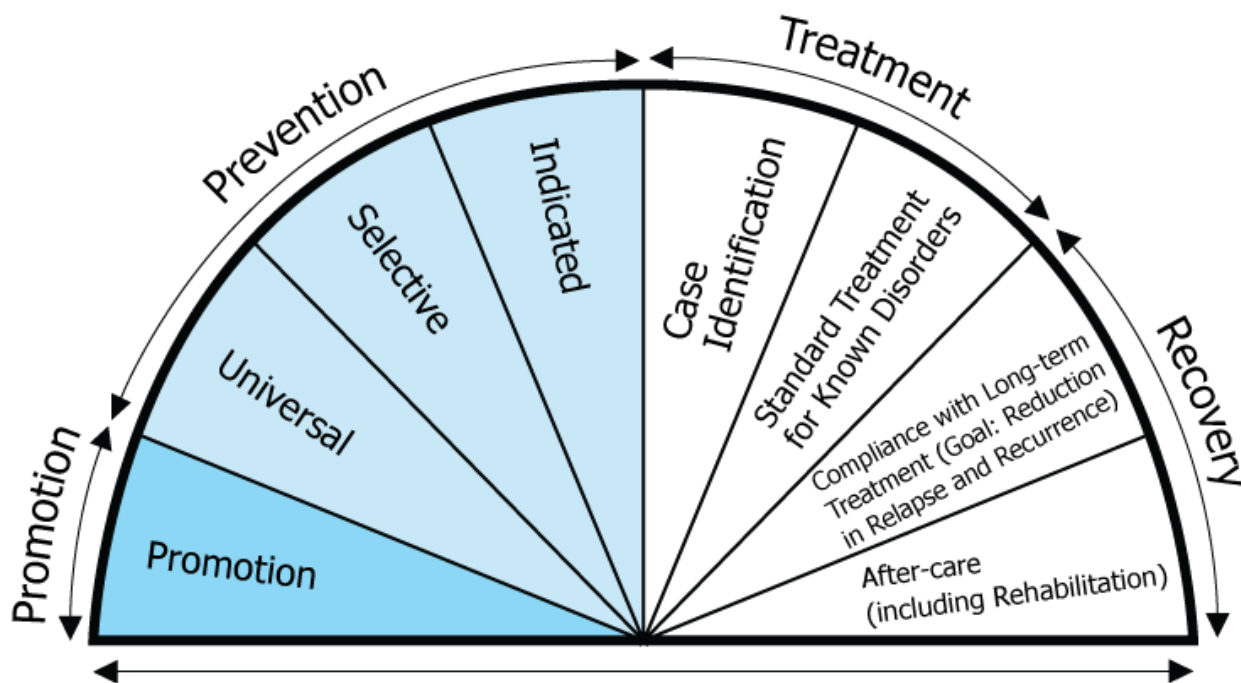
The Division's Units provide a comprehensive approach to attainment of six overarching goals. These goals are consistent with those of SAMHSA's National Behavioral Health Quality Framework and include:

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 Behavioral 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. BHDDH administers a system of care that provides treatment and recovery supports to over 44,000 Rhode Islanders in CY 2016, which is about 4% of the total RI population. It administered a system of care that provides treatment and recovery supports to over 44,000 Rhode Islanders in CY 2016, which is about 4% of the total RI population. BHDDH's system of care consists of 30 licensed providers with 119 service sites.

Of the 37,517 individuals over the age of 18 served by the public mental health system, 24,505 received mental health services and/or 16,030 received substance abuse services; and of the 6,531 individuals

under the age of 18, 6,418 received mental health services and/or 150 individuals received substance abuse services (n=150).

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BHDDH's system of care consists of 30 licensed providers with 119 service sites. Seven of the licensed providers are CBHO which provide 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.

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) administers a system of care that provides treatment and recovery supports to over 44,000 Rhode Islanders in CY 2016, which is about 4% of the total RI population. BHDDH's system of care consists of 30 licensed providers with 119 service sites.

Of the 37,517 individuals over the age of 18 served by the public mental health system, 24,505 received mental health services and/or 16,030 received substance abuse services; and of the 6,531 individuals under the age of 18, 6,418 received mental health services and/or 150 individuals received substance abuse services (n=150).

About 8,513 individuals over age 18 served by Rhode Island's BHDDH-licensed community mental health centers (CMHC) received Integrated Health Home services, while 1,438 received the higher acuity services under the Assertive Community Treatment program. The remaining 14,554 individuals were served in general outpatient.

There were 6,340 Individuals over age 18 receiving substance abuse services under the Medication Assisted Treatment and/or 3,196 receiving Opioid Treatment Program Health Home services (OTP-HH).

The CMHCs and OTPs also serve many of the state's homeless, and of those adults served by the Behavioral Health system for whom housing data was available, 1,928 were homeless in CY 16, with the proportion higher for those receiving MH services, 1.76%, and about 11% of the individuals received both mental health and substance use services.

In 2016, BHDDH served 1,279 individuals who identified as Veterans or active military, although the status of about 14% of all adults served was not known and many people with military experience may not have identified as such.

Criterion 3: Children's' Services -DCYF provides a robust array of home and community based services to residential services to children (SED) at risk of serious emotional disturbance and children/youth diagnosed with SED. DCYF licenses all out of home placements for children and youth that are funded by DCYF including foster homes, group home and residential sites. DCYF also licenses day care providers and day care facilities. DCYF provides services through a system of care philosophy and has 122 contracts with community providers. Services are provided to children and youth involved with DCYF. DCYF has a number of programs and services for children and families not involved with DCYF that provide diversionary and preventative support and services to promote wellness.

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 its 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 65 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 services for adults with mental health issues or substance use for 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 for adult services and substance use disorders receive 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.

In the children's system, training is provided by a variety of different organizations. For those programs that are evidenced based practices, the training is through the organization that oversees the fidelity to the model. DCYF provides some training opportunities such as trauma informed training, special training for

kin and foster care parents. DCYF provides monthly training on using the evidence based functional assessment tool, the Child Adolescent Needs and Strength (CANS) for community providers.

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.

Healthy Transitions RI uses the EBP, Coordinated Specialty Care, to provide developmentally appropriate services to youth and young adults aged 16-25, to identify and address mental health and substance use issues early to mitigate long-term physical and psychological damages. The model uses a team approach to services and supports in community based settings which are identified through a shared decision making model. The youth/young adults are actively engaged in treatment planning and treatment. Services and supports identified include case management, individual or group psychotherapy, supported employment and education services, family counseling/education/support, nursing services, psychiatric evaluation, and medication management.

RI's Healthy Transition programs provide services and supports to youth and young adults who have or at risk of having a serious mental illness or first episode psychosis. Diagnostic categories include: Schizophrenia spectrum and other Psychotic disorders, Bipolar, Depressive, Anxiety, Obsessive Compulsive, Trauma and stress related, Dissociated

At its core, CSC is a collaborative, recovery-oriented approach involving participants, treatment team members, and when appropriate, relatives, as active participants. Treatment plans address the unique needs, preferences, and recovery goals of individuals with or at risk of SMI or FEP. Services are highly coordinated with primary medical care, with a focus on optimizing a participant's overall mental and physical health.

RI plans to continue to implement the HT grant through available federal funding opportunities. These funds are available through 2018 and may be available through 2019. We are working on activities to sustain implementing CSC post grant funding.

Question 9: Currently, the set aside is given to the two Healthy Transition Pilot programs. The data collected for Healthy Transitions includes NOMs data reported to SPARs as well as local evaluation data. Local evaluation data includes service delivery and outcome measures. The local evaluation workgroup is starting to analyze and report on outcome and program fidelity measures.

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 below

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. DCYF is working on system to better track substance exposed newborns and specifically infants diagnosed with NAS. 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 Connect is a DCYF program specifically developed to strengthen substance abuse-affected families. Service duration may be up to one year and includes home-based substance use identification, assessment, counseling and linkage to formal treatment programs; individual (adult and child) and family assessment, counseling and crisis intervention; parent services to recover from addiction; ongoing home visits by a pediatric nurse whose primary function is to monitor the health and safety of children in the home; and aftercare services as a follow up supportive measure for families who have received one (1) year of Project Connect services and/or have been closed to DCYF.

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 care 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. Domestic violence advocates work closely with DCYF; advocates are co-located in the Child Protection unit and are available to the FCCPs.

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 must 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 State'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 State'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
- ix. Wraparound services through Family Care Community Program.

As described in Step 1, BHDDH applied for and received a Screening, Brief Intervention and Referral to Treatment (SBIRT) for adults. 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.

DCYF maintains its commitment to ensuring that staff receive the training necessary to do their job, that supervisors have the skills, knowledge, and experience to provide effective leadership to promote improvements in safety, permanence and well-being for children, youth and families. DCYF has internal staff training for case workers, supervisors and administrative staff and staff trainers for foster and kinship care providers.

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

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.

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 state agencies, 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.

Needs

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.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

Step 2 Unmet service needs and critical gaps, for the specified populations and the data used to identify these needs.

Unmet Service need for children/youth not open to DCYF to access evidence based services:

As noted in the 2017 Kids Count *Factbook*, “in Rhode Island, one in five (19.0%) children ages six to 17 has a diagnosable mental health problem; one in ten (9.8%) has significant functional impairment.” but “34% of Rhode Island children who needed mental health treatment or counseling in the past 12 months did not receive it”. Rhode Island is ranked # 15 in the US for having one of the lowest rates (3.4%) of children who do not have health insurance in 2015 according to the US Census Bureau. These children and youth have insurance coverage and have a need for service but have not accessed the full range of children’s mental health services. Bradley Hospital for children/youth with mental health disabilities and the ARTS programs have seen a recent increase in the number of children/youth who are receiving this high level of services but become “stuck” in this level of service because there is a lack of available step down services. Most of these children/youth have already received services in their home setting or had been placed in congregate care. There are children/youth in congregate care that could be placed back at home or in a lower level of care but there has not been sufficient community based services to help move children/youth safety back to the community.

What DCYF is currenting doing to meet these needs:

DCYF has completed an expansion of evidence based services and community based services to assist in helping to transition children and youth in placement back to a community setting and to keep children/youth in the community safety with services. DCYF has been working on developing a system of care for children that is more cohesive and integrated with easier access to a more robust array of services for children and youth not involved with DCYF. DCYF is re-assessing the current practice of seeking a voluntary petition when a child/youth needs an out of home residential treatment program. DCYF is working to develop a system for accessing community based services if needed by a child/youth not open to the department. DCYF will be continuing to fund a family service organization to help educate, advocate and support families with children at risk of SED or already diagnosed as SED who are having difficulty navigating the system.

Unmet Service need for transitioning youth accessing services and critical gaps within the current system:

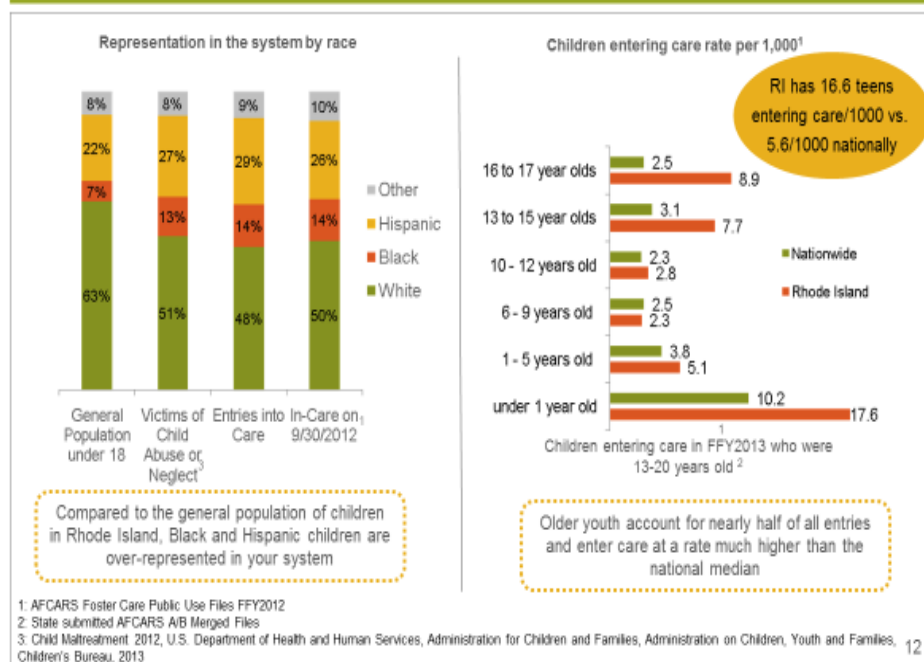
Challenges exist for transitioning youth related to accessing existing services, lack of specific services in the area of substance use and housing resources for this age group and the need for coordination and collaboration between different state agencies to provide services. Youth in the foster care system are at higher risk for homelessness, mental health issues, unemployment, and substance abuse. Often these youth do not have a support system of caring adults to help them in transitioning to adulthood.

What DCYF is currenting doing to meet these needs of transitioning youth:

DCYF staff is working with BHDDH and other state agencies to develop new systems and programs and/or revise existing system issues and looking at better ways to provide services to this population. DCYF is working collaboratively with BHDDH on two grants that address this age group and the need to have a plan to improve community based services in addition to positive outcomes.

Unmet Service need: Reducing the unnecessary reliance on congregate care:

Like most systems, DCYF children in care are disproportionately children of color, but unlike most systems, they are more likely to be older youth



DCYF continues to have a high number of children and youth in out of home care; as of July 2017, there was a daily average of 451 children/youth in out of home placements. Children in care have been disproportionately children of color and older youth. DCYF has made significant progress in reducing the overall number of children in group placement from 839 children in 2008 to 504 children in 2013. By 2015 the number of children and youth in out of home care had started to increase again. However, there was a decrease in the number of younger children placed in congregate care. The percent of children age 12 or under decreased from 7.7% in 2013 to 5.6% in 2015. There are an average of 450 children/youth per day in group placement as of August 2017

What DCYF is currenting doing to meet these needs:

DCYF has been working on diligent recruitment of new foster parents; parent and relative searches for children and youth in care; development and delivery of training for new foster parents; and an extensive procurement of new support services for resources and kin foster parents designed to help both the foster parent and the youth. There have been special recruitment efforts for older youth, siblings, minority children and LGBTQ youth.

Other significant activities have been the development of an expanded robust service array that includes community based and evidence based services to help children and youth return home or be able to stay with their family with supports and resources. There are internal processes that have been developed to provide gatekeeping to ensure that the most appropriate services for children and youth are provided through the Director's Approval Process. A special effort is being made to not place young children in group settings unless absolutely necessary. And for those youth in placement, the Expedited Permanency Meeting (EPM) provides a comprehensive review process to ensure that children waiting in placement receive the services and support they need immediately. CSBS has initiated a Utilization Management process to identify and address the needs of youth who would benefit from a lower level of service.

Step 3: Prioritize state planning activities

The area that will be addressed in the MHBG based on the information in Step 2 is the need for children /youth not open to DCYF to access evidence based services. DCYF will continue to fund a family service organization to help educate, advocate and support families with children at risk of SED or already diagnosed as SED. The type of the activities to be performed by the family service organization include operating a warm line to provide information about services in the community, providing workshops and conferences with a focus on family involvement, and providing support and advocacy services to children, youth and families not open to DCYF.

Step 2 Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

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-5 diagnoses of illicit drugs dependence or abuse; DSM-5 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

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

(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 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 - 2015²

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 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 - 2015¹

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

² Rhode Island's Strategic Plan on Addiction and Overdose: Four Strategies to Alter the Course of an Epidemic. Rhode Island Governor's Overdose Prevention and Intervention Task Force, November 4, 2015.

<http://preventoverdose.ri.org/the-task-force/>

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 first 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 facilities 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 represent the

³ National Alliance to End Homeless, State of Homelessness Report 2014, www.naeh.org

⁴ RI Homeless Management Information System

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 Governor'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 use 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 marijuana 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, marijuana 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 continued 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 lessening 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 between 1945-65, 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

Children are removed from their home if parents have substance use or have a mental health disorder that prevents them from being able to care for their children safely. For children age 0-11 who were removed

from their home in FY 2016, the second most frequent reasons was due to parent drug/alcohol use (45.3%) and the third was caretaker's inability to cope (20.1%). For children aged 12 and older who were removed from their home in FY 16, the most frequent removal reason was child behavior problem (64.3%) and second reason was caretaker inability to cope (18.2%). This data is from DCYF Permanency Report, July 1, 2012-2016. http://www.dcyf.ri.gov/docs/reports/DRAFT_FY13-16_permanency_entry_cohortv4final.pdf

For those families where alcohol, drug use or mental disorder was a factor in the removal of a child, DCYF works with the family members to provide services so that children and youth can safely return home as soon as possible with community supports. One program that specifically addresses this problem is Project Connect which provides assessment, counseling and linkage to formal treatment programs. DCYF also work to ensure that parents are connected to community resources for necessary treatment,

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.

State Epidemiological Outcomes Workgroup (SEOW): The Rhode Island State Epidemiological Outcomes Workgroup's (SEOW) main goal is to institutionalize data-driven decision making for state and community level prevention planning and to expand the focus to integrate behavioral health indicators such as preventing mental illness and promoting positive mental health as it relates to substance use and mental health. Overall, data points on consumption patterns (i.e., current smoking and drinking, or age of first use) and mental health (i.e., depression symptoms or suicide attempts) from various sources will be integrated into a single data-file under the proposed data collection activities. Medicaid utilization of mental health services, number of children receiving mental health services for emotional disorders, and psychiatric hospitalization admissions, suicide ideation/plans/attempts/deaths, were added to the already existing substance use data collected under the previous SEOW project. Every effort will be made to identify and access additional sources of potential behavioral health indicators (such as episodes of depression, psychological distress, suicide ideation/attempt, etc.) and intervening variables (such as domestic violence, child abuse, etc.).

Based on these data, state-level and community-level epidemiological profiles were developed for the promotion, prevention, treatment, recovery, and policy implications for Rhode Island health care system. SEOW informs and recommends priorities for the State of Rhode Island based on the community and state-level epidemiological profile. In 2015 the SEOW conducted a state level needs assessment using current data regarding the consequences of substance use and substance use consumption patterns. In 2016 the SEOW updated the needs assessment to include additional indicators associated with overdose. The following statewide priorities were identified: proportion of underage population using marijuana in the past month still remains above the national average; rates of DSM-IV alcohol and drug abuse or

dependence by age group across time were higher in RI as compared to the United States; higher rates of drug overdose above the national average; youth suicide attempts higher than the national average and rates of RI population needing but not receiving treatment for drug and alcohol use exceed the national averages.

In 2013 the State of Rhode Island was awarded the SAMHSA Strategic Prevention Framework Partnership for Success grant. This five-year initiative continued the partnership between Brown University and the State of Rhode Island that was developed over the previous ten years. The SEOW membership includes the Governor's Council on Behavioral Health; the Departments of Health, Children, Youth and Families; and Elementary and Secondary Education; representation from the juvenile and adult justice systems; the University of Rhode Island; and members from the community behavioral health services systems.

KEY FINDINGS AT A GLANCE

- Recent (past month) use of illicit drugs and marijuana are still major concerns among Rhode Islanders of ***all age groups*** especially since prevalence rates exceed the national averages. RI excess is greatest for past month marijuana use followed by past month illicit drug use.
- Drug abuse or dependence remains a concern across ***all age groups***; and needing but not receiving treatment for drug use is of particular concern among adults aged 26 years and older.
- Black ***high school students*** in RI as compared to the US are at a higher risk of ever cocaine use and ever methamphetamine use, while Asian and White ***high school students*** are at a high risk for current marijuana use.
- Substance abuse admissions for heroin from 2012-2014 have dramatically increased. More data are needed to identify the key demographic populations at risk.
- Compared to the US, RI adults aged ***18-25 years*** have a greater unmet need for treatment for DSM-IV alcohol abuse/dependence.
- RI adults aged ***26+ years*** have higher prevalence of serious mental illness in the past year, any mental illness in the past year, and having had at least one major depressive episode in the past year relative to national averages.
- Drug-related overdose deaths are a primary concern for RI. Data collection that can distinguish between prescription drug and street drug overdose is needed to better understand the nature of this problem.

SUBSTANCE USE

- RI as compared to the US across ***all age groups*** (12+ years) over time fare worse with higher prevalence rates for any illicit drug use in the past month, marijuana use in the past month, and DSM-IV drug abuse or dependence.
- RI adults ***aged 26+*** report needing but not receiving treatment for drug use more than US averages.
- ***All age groups*** (12+ years) of Rhode Islanders perceive less risk of smoking marijuana once a month than the national average (Table 2.1.2); 18-25 year olds had the least concern over monthly marijuana use relative to the national average.
- There have been significant increases in the number of substance abuse admissions for heroin from 2012-2014 (Table 2.1.6), and slight increase in the number of substance abuse admissions for minors and 22-30 year olds.

- Among the **high school student** population, RI fares better than the national average for smoking cigarettes, use of tobacco before age 13, use of marijuana before age 13 and prescription drug misuse in the past year.
- Additionally, when reporting by racial or ethnic disparities in **high school youth**, RI Black high school students as compared to national averages were at a higher risk for ever cocaine use and ever methamphetamine use (Table 2.1.10).
- Asian and white RI **high school students** have higher prevalence of current marijuana use compared to national averages (Table 2.1.10).

Table 2.1.2. RI vs. US Perceptions of Great Risk of Smoking Marijuana Once a Month (%) by Age Group, 2007-2014

	2007-08				2011-2012				2012-2013				2013-2014			
Age Group	12 +	12-17	18-25	26 +	12 +	12-17	18-25	26 +	12 +	12-17	18-25	26 +	12 +	12-17	18-25	26 +
RI	32.38	29.57	15.91	35.79	23.89	20.08	11.39	26.76	22.18	20.46	10.79	24.59	21.12	18.94	9.06	23.67
US	37.66	33.91	23.69	40.56	31.37	27.02	17.37	34.36	29.50	25.34	15.81	32.40	27.35	23.54	14.22	30.09
RI/US Ratio	0.86	0.87	0.67	0.88	0.76	0.74	0.66	0.78	0.75	0.81	0.68	0.76	0.77	0.80	0.64	0.79

Please note that this table contains the most recently published data on this indicator.

Table 2.1.6. Rhode Island Substance Abuse Admissions, 2012-2014

	2012	2013	2014
Total (N)	14015	14783	14406
Gender			
Male	9513 (68%)	10055 (68%)	9741 (68%)
Female	4502 (32%)	4728 (32%)	4665 (32%)
Age Group			
Under 18	52 (0.5%)	140 (1%)	398 (3%)
18-21	643 (5%)	684 (5%)	878 (6%)
22-30	3142 (22.5%)	3781 (25%)	3982 (27%)
31-45	5614 (40%)	5777 (39%)	5303 (37%)
45-65	4381 (31%)	4244 (29%)	3738 (26%)
Over 65	183 (1%)	157 (1%)	107 (1%)
Race/Ethnicity			
Native American	180 (1%)	159 (1%)	141 (1%)
Asian	77 (0.5%)	79 (0.5%)	80 (0.5%)
Black	1071 (8%)	1010 (7%)	977 (7%)
Hawaiian/Pacific Islander	40 (0.5%)	75 (0.5%)	60 (0.5%)
Hispanic	1158 (8%)	1100 (7%)	953 (7%)
Unknown	515 (4%)	526 (4%)	644 (4%)
White	10974 (78%)	11834 (80%)	11551 (80%)
Primary Substance			

Alcohol	5536 (39.5%)	5699 (39%)	5292 (37%)
Cocaine	1140 (8%)	1107 (7.5%)	1095 (7.5%)
Marijuana	1680 (12%)	1550 (10.5%)	1296 (9%)
Heroin	2875 (20.5%)	3649 (25%)	4431 (31%)
Other	2784 (20%)	2778 (19%)	2292 (16%)

NOTE: These data reflect number of treatment admissions, not number of people as there may be multiple admissions for the same person during a calendar year.

Source: Rhode Island Behavioral Health On-Line Data Service (BHOLD)

There is a pending data request for date for 2015 and 2016; table will be updated once the request is fulfilled.

Table 2.1.7. RI vs. US Substance Consumption for High School Students, 2009-2015

% of Students (grades 9-12) Reporting:	2009			2011			2013			2015		
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US
Cigarette Use												
Smoking cigarettes 20+ days past month	5.4	7.3	0.74	4.4	6.4	0.69	3.1	5.6	0.55	1.5	3.4	0.44
Initial use of tobacco before age 13	8.4	10.7	0.79	7.1	10.3	0.69	5.6	9.3	0.60	5.5	6.6	0.83
Marijuana Use												
Using marijuana past month	26.3	20.8	1.26	26.3	21.3	1.23	23.9	23.4	1.02	23.6	21.7	1.08
Initial use of marijuana before age 13	8.3	7.5	1.11	7.1	8.1	0.88	6.8	8.6	0.79	6.7	7.5	0.89
Prescription Drug Use												
Prescription drug misuse past year	--	--	--	14.1	20.7	0.68	13.5	17.8	0.76	11.6	16.8	0.69

Note Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: Youth Risk Behavior Surveillance Survey (YRBSS)

Table 2.1.10. Racial/Ethnic Disparities in High School Substance Use, 2015

	Asian	Black	Hispanic	White	Multiple Race
Current Cigarette Use					
RI	2.3	2.2	3.7	5.4	7.7
US	7.0	6.5	9.2	12.4	14.2
RI/US Ratio	0.33	0.34	0.40	0.43	0.54
Current Alcohol Use					
RI	12.6	20.0	26.5	27.5	27.7
US	13.1	23.8	34.4	35.2	39.6
RI/US Ratio	0.96	0.84	0.77	0.78	0.70
Current Marijuana Use					
RI	9.9	24.4	23.0	24.2	26.1
US	8.2	27.1	24.5	19.9	23.5
RI/US Ratio	1.20	0.90	0.94	1.22	1.11
Ever Prescription Drug Abuse					
RI	2.6	9.0	11.4	11.2	14.7
US	9.7	14.8	17.5	16.5	24.7
RI/US Ratio	0.27	0.61	0.65	0.68	0.59
Ever Used Cocaine					
RI	0.8	7.2	7.8	2.9	4.7
US	3.4	3.8	8.0	4.1	5.8
RI/US Ratio	0.23	1.89	0.97	0.71	0.81

NOTE: American Indian or Alaskan Native and Native Hawaiian or other Pacific Islander were excluded due to small sample size in RI. Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: Youth Risk Behavior Surveillance System (YRBSS)

3. ALCOHOL USE

- Alcohol consumption across *all age groups* in RI as compared to the US was larger in prevalence. In particular, the *18-25 age group* was at the most risk for alcohol abuse or dependence and needing but not receiving treatment for alcohol use.
- Alcohol consumption indicators for *high school students* including past month use, binge drinking in the past month, use of alcohol before age 13, drinking and driving in the past month, and being in the car with a driver who had been drinking in the past month, all had lower prevalence in RI as compared to the US in the past three data collection points (2009, 2011, and 2013; Table 2.2.3).

- As evident from data shown in Table 2.2.4, when alcohol consumption for **high school students** were compared regionally, RI high school students were lower in prevalence compared to other regional states for ever had at least one drink of alcohol and binge drinking in the past month.

• **Table 2.2.3. RI vs. Region Alcohol Consumption for High School Students, 2009-2015**

% of Students (grades 9-12) Reporting:	2009			2011			2013			2015		
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US
Alcohol Use												
Alcohol use past month	34.0	41.8	0.81	30.0	38.7	0.78	30.9	34.9	0.89	26.1	32.8	0.80
Binge drinking past month	18.7	24.2	0.77	18.3	21.9	0.84	15.3	20.8	0.74	12.8	17.7	0.72
Initial use of alcohol before age 13	15.8	21.1	0.75	15.6	20.5	0.76	13.5	18.6	0.73	11.4	17.2	0.66
Drinking and driving past month	7.2	9.7	0.74	6.5	8.2	0.79	8.5	10.0	0.85	--	7.8	--
In car w/ driver who had been drinking (past month)	23.1	28.3	0.82	21.9	24.1	0.91	20.1	21.9	0.92	17.5	20.0	0.88

Note Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average.

Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: Youth Risk Behavior Surveillance System (YRBSS)

When comparing regional alcohol consumption for the underage population (Table 2.2.4) in 2013, Rhode Islanders had lower rates of consumption than Connecticut, Massachusetts, New Hampshire, New Jersey, New York, and Vermont. The initial use of alcohol before age 13 and percentage reporting drinking and driving in the past month for Rhode Islanders are similar to comparison states.

Table 2.2.4. RI vs. Region Alcohol Consumption among High School Students, 2001-2015

	USA	RI	CT	MA	ME	NH	NJ	NY	PA	VT
Ever had at least one drink of alcohol										
2001	78.2	78.8	--	81.2	--	--	83.4	--	--	--

2009	72.5	63.9	--	71.3	65.2	68.5	74.6	--	70.5	--
2011	70.8	62.0	--	67.5	59.0	67.1	69.1	--	--	--
2015	63.2	52.5	--	61.3	53.2	--	--	--	60.8	--
% Binge drinking (5+ drinks in one sitting) past month										
2001	29.9	30.7	--	32.7	31.5	--	32.6	--	--	29
2009	24.2	18.7	24.2	24.5	--	24	26.7	23.8	21.9	23.1
2011	21.9	18.3	22.3	22.2	16.2	23.8	23.7	22	--	20.9
2013	20.8	15.3	20	18.9	14.4	17.3	23	18.4	--	21.4
2015	17.7	12.8	14.0	17.7	11.7	16.8	--	15.6	15.4	16.0
% Initial use of alcohol before age 13										
2001	29.1	29.7	--	27.9	21.7	--	32.5	--	--	26
2009	21.1	15.8	17.6	17.2	20.3	14.8	18	21	19	18.2
2011	20.5	15.6	15.6	14.6	15.8	14.3	14.4	19	--	14.8
2013	18.6	13.5	14.9	--	13.3	11.9	14.6	--	--	16.2
2015	17.2	11.4	10.6	12.9	13.6	10.8	--	16.1	13.1	12.3
% Drinking and driving past month										
2001	13.3	15.5	--	12.2	10.8	--	13	--	--	10.1
2009	9.7	7.2	8.7	9	--	8.5	7.7	10	6.9	8
2011	8.2	6.5	6.9	6.5	--	8.6	6.4	5.4	--	7.1
2013	10	8.5	9.4	7.1	6.6	8.4	8.7	10.2	--	10.2
2015	7.8	--	7.4	9.4	4.6	6.3	8.7	8.0	5.4	7.2

Note: **RI Indicators greater than national averages are shown in red.** RI indicators less than national averages are shown in green.

Source: Youth Risk Behavior Surveillance System (YRBSS)

4. MENTAL HEALTH

- In 2014-15, RI adults across **aged 26+** had a higher prevalence of any mental illness in the past year relative to national averages.
- In 2013-14, RI adults had a higher prevalence of any mental illness in the past year than all other Northeastern states (Table 2.3.3).
- In Rhode Island, the number of mental health treatment admissions by **minors (<18)** has increased substantially from 2012 to 2014, while treatment admissions for **seniors (65+)** have decreased (Table 2.3.4).

Table RI vs. US Adult Mental Health Indicators, 2009-2015

Age Group	18+			18-25			26+		
Serious Mental Illness in the Past Year (%)									
	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	R
2009-2010	4.92	3.88	1.27	4.38	3.63	1.21	5.02	3.92	
2011-2012	4.25	3.97	1.07	4.27	3.95	1.08	4.25	3.98	
2012-2013	4.90	4.14	1.18	4.47	4.17	1.07	4.99	4.14	

2013-2014	4.77	4.15	1.15	4.79	4.52	1.06	4.76	4.09
2014-2015	4.51	4.05	1.11	5.13	4.92	1.04	4.39	3.91
Any Mental Illness in the Past Year (%)								
2009-2010	21.30	18.10	1.18	19.42	18.02	1.08	21.65	18.11
2011-2012	18.80	18.19	1.03	18.80	19.06	0.99	18.81	18.04
2012-2013	20.13	18.53	1.09	19.93	19.50	1.02	20.17	18.36
2013-2014	21.60	18.29	1.18	21.09	19.75	1.07	21.70	18.05
2014-2015	20.50	18.01	1.14	22.01	20.89	1.05	20.22	17.52
Had at Least One Major Depressive Episode in the Past Year (%)								
2009-2010	7.95	6.70	1.19	9.33	8.15	1.14	7.69	6.45
2011-2012	7.65	6.72	1.14	8.79	8.61	1.02	7.43	6.39
2012-2013	8.46	6.77	1.25	9.74	8.81	1.11	8.21	6.41
2013-2014	7.68	6.63	1.16	9.89	9.00	1.10	7.27	6.22
2014-2015	7.08	6.64	1.07	9.81	9.79	1.00	6.57	6.11

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average.

Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

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

Table 2.3.3. RI vs Region Adult (18+) Mental Health, 2009-2014

	CT	MA	ME	NH	NJ	NY	PA	VT	RI
2009-10									
Past Year Serious Mental Illness (%)	3.73	4.20	4.14	4.25	3.39	3.72	3.57	4.04	4.92
Past Year Any Mental Illness (%)	17.63	18.51	18.70	19.76	17.54	19.02	17.53	19.75	21.30
At Least 1 Major Depressive Episode Past Year (%)	6.25	7.23	6.85	7.23	6.10	6.75	6.62	6.98	7.95
2011-12									
Past Year Serious Mental Illness (%)	3.24	3.71	4.38	4.05	3.05	3.60	4.06	4.74	4.25
Past Year Any Mental Illness (%)	16.71	17.38	20.05	18.53	14.66	18.61	17.99	19.39	18.80
At Least 1 Major Depressive Episode Past Year (%)	6.20	6.19	7.33	7.17	5.43	6.24	6.89	7.79	7.65
2012-13									
Past Year Serious Mental Illness (%)	3.38	4.25	4.94	3.94	3.28	3.75	4.05	5.48	4.90
Past Year Any Mental Illness (%)	17.26	19.34	21.36	18.64	15.62	18.69	17.96	19.74	20.13
At Least 1 Major Depressive Episode Past Year (%)	6.28	6.66	8.02	6.90	6.12	6.36	6.56	7.61	8.46
2013-14									
Past Year Serious Mental Illness (%)	3.53	4.23	5.33	4.73	3.56	3.76	4.00	5.50	4.77
Past Year Any Mental Illness (%)	16.44	20.11	20.55	20.86	16.27	17.63	17.52	20.46	21.60
At Least 1 Major Depressive Episode Past Year (%)	6.03	7.50	8.21	7.90	6.47	6.32	6.61	7.94	7.68

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

5. CONSEQUENCES

- As evident from data shown in Table 2.4.0, several long-term adverse consequences remain elevated in Rhode Island, as compared to the national averages. This is especially the case for diseases of heart deaths, chronic liver disease and cirrhosis deaths, deaths from fatal motor vehicle crashes involving alcohol, DSM-IV alcohol abuse and dependence, and DSM-IV drug abuse and dependence, whose rates have remained greater in Rhode Island relative to the national averages from 2004 to 2012.
- Drug-related overdose deaths per 100,000 population were significantly higher in RI than in all other states in the region and almost twice the national average (Table 2.4.2 and Figure 2.4.2).
- Emergency department visits in RI for prescription drug overdose have increased from 2010 to 2014; approximately one quarter of visits were for residents under the age of 21 years (Table 2.4.3).
- Hospital admissions related to prescription drug overdose in RI have actually decreased from 2010 to 2014; about 17% of admissions were for residents under age 21 years (Table 2.4.3).
- In 2013 RI **high school students** report a significantly higher rate of attempting suicide (Table 2.4.4) than national averages, despite having lower rates of considering suicide and planning suicide; however, this rate subsided in most recent 2015 YRBS data.

Table 2.4.0. RI vs US Potential Adverse Consequences of Substance Use, 2007-2014

Substance Use Consequences Indicators:	2007			2010			2012			2014		
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US
Malignant Neoplasms Deaths	2.09	1.87	1.12	2.15	1.86	1.16	2.045	1.856	1.10	2.12	1.86	1.14
Diseases of Heart Deaths	2.60	2.04	1.27	2.21	1.94	1.14	2.25	1.91	1.18	2.21	1.93	1.15
Chronic Lower Respiratory Diseases Deaths	0.40	0.42	0.94	0.48	0.45	1.08	0.48	0.46	1.05	0.48	0.46	1.04
Chronic Liver Disease and Cirrhosis Deaths	0.11	0.10	1.15	0.12	0.10	1.14	0.13	0.11	1.19	0.11	0.12	0.92
Intentional Self-harm (Suicide)	0.09	0.12	0.79	0.12	0.12	0.99	0.10	0.129	0.78	0.11	0.13	0.85
Assault (Homicide)	0.02	0.06	0.38	0.03	0.05	0.49	0.029	0.053	0.55	--	--	--
Fatal MV Crashes inv. Alcohol	31%	31%	1.00	40%	31%	1.29	39%	30%	1.30	--	--	--
Drivers in Fatal MV Crashes inv. Alcohol*	33%	26%	1.27	36%	26%	1.38	34%	25%	1.36	--	--	--
Violent Crime	2.27	4.72	0.48	2.57	4.05	0.63	2.52	3.87	0.65	2.19	3.76	0.58
Property Crime	26.23	32.76	0.80	25.57	29.46	0.87	25.72	28.59	0.90	21.74	25.96	0.84
DSM-IV Alcohol Abuse/Dependence	7.8%	7.5%	1.04	9.1%	6.8%	1.34	8.5%	6.7%	1.27	--	--	--
DSM-IV Drug Abuse/Dependence	4.4%	2.8%	1.57	2.9%	2.7%	1.07	3.7%	2.7%	1.37	--	--	--

Note: Ratios greater than 1.14 indicate those consequences where RI exceeds the national average. Ratios less than 0.86

indicate those consequences where RI is below the national average.

All rates are per 1,000 population, except for data denoted with % (i.e., shown per 100 population).

* Alcohol-impaired driving - at least one driver or motorcycle rider had a BAC of 0.01 or higher

** Violent and Property Crimes U.S. Data taken from 2012 Table 1 Data

Sources: Fatality Analysis Reporting System (FARS), National Vital Statistics System (NVSS), Uniform Crime Reports (UCR)

Since 2010, RI has consistently surpassed the national average for drug-related overdose deaths. RI also has consistently fared worse than all other northeastern states in terms of drug-related overdose deaths (Table 2.4.2). 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). Given the broad scope encompassed by “drug-related overdose deaths,” it is challenging to infer intervention implications.

Table 2.4.2. RI vs. Region Drug-Related Overdose Deaths per 100,000 Population

	USA	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2010	12.5	16.0	--	11.3	10.2	12.2	9.9	8.1	15.2	9.9
2011	13.3	18.1	--	13.0	11.7	16.0	11.5	10.0	17.9	13.3
2012	13.3	18.7	--	12.9	11.4	13.1	13.8	10.8	18.5	11.5
2013	13.9	23.0	--	16.2	12.9	15.4	14.6	11.8	19.0	15.0

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average.

Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

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

Emergency department visits in RI for prescription drug overdose have increased from 2010 to 2014, though the number of visits peaked in 2012. Approximately one quarter of emergency department visits were for residents under the age of 21 years, though this proportion appears to be slowly decreasing. Hospital admissions related to prescription drug overdose in RI have actually decreased from 2010 to 2014, though there was an increase from 2013 to 2014. About 17% of hospital admissions were for residents under the age of 21 years—and this proportion has remained steady (Table 2.4.3). A key limitation of these data is that prescription drug overdose visits or admissions could be due to prescription drug use (e.g. opioids, benzodiazepines, stimulants) or street drug use (e.g. fentanyl, heroin). Again this limitation is a barrier for inferring intervention implications.

Table 2.4.3. Prescription Drug Overdose in Rhode Island, 2010-2014

ED Visits Related to Prescription Drug Overdose					
	2010	2011	2012	2013	2014
Total	362,440	367,635	380,323	371,010	375,342
Under 21 (%)	26	25	24	23	23

21+ (%)	74	75	76	77	77
Hospital Admissions Related to Prescription Drug Overdose					
Total	132,147	130,832	126,358	120,786	124,243
Under 21 (%)	17	17	17	17	16
21+ (%)	83	83	83	83	84

Source: Hospital Database, Rhode Island Department of Health

RI high school students are less likely to consider suicide or plan suicide than the national average. However, RI high school students were more likely to attempt suicide than the national average in 2013 (Table 2.4.4). Yet, the 2015 prevalence for suicide attempts among high school students has decreased since 2013. RI adults were more likely to have thoughts of suicide in the past year than the national average, particularly for adults aged 26 years or more (Table 2.4.5).

Table 2.4.4. RI vs. US Suicide-Related Indicators, 2009-2015

% of Students (grades 9-12) Reporting:	2009			2011			2013			2015
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI
Considered Suicide	11.8	13.8	0.86	12.3	15.8	0.78	13.9	17.0	0.82	14.1
Planned Suicide	11.3	10.9	1.04	10.7	12.8	0.84	9.9	13.6	0.73	12.1
Attempted Suicide	7.7	6.3	1.22	8.7	7.8	1.12	14.3	8.0	1.79	10.6

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: Youth Risk Behavior Surveillance Survey (YRBSS)

Table 2.4.5. RI vs. US Thoughts of Suicide Past Year, 2009-2015

% of Age Group Reporting:	18+			18-25			26+		
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US
2009-2010	4.56	3.78	1.21	6.90	6.36	1.08	4.11	3.33	1.23
2011-2012	4.05	3.77	1.07	6.89	7.03	0.98	3.51	3.21	1.09
2012-2013	4.33	3.89	1.11	7.34	7.33	1.00	3.75	3.30	1.14
2013-2014	4.21	3.94	1.07	7.92	7.44	1.06	3.50	3.34	1.05
2014-2015	4.42	3.99	1.11	8.62	7.88	1.09	3.65	3.34	1.09

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

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

There is a need for work to be done to make a difference for both short- and long-term consequences. Again, the data presented here regarding substance or alcohol and health consequences are not causal. There are many reasons and factors contributing to these various short- and long-term consequences ultimately leading to death.

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

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

DCYF has RICHIST and RIFIS systems that collect data for Child Welfare, Juvenile Justice, Mental Health, and for Medicaid services. Data is available on individual level without identifying information and on a system level.

Quality and Data Collection Readiness

1. BHDDH currently collects client-level data from all BHDDH-licensed behavioral healthcare providers on all of their clients, regardless of payment source. Some service providers forward a monthly upload of their data which subsequently is entered into the data collection system; other providers enter data directly into the system. Data are collected on all the national outcome measures and BHDDH also has the capability to collect some state-level measures. Data may be disaggregated by provider, program, and client identifier.

At present, BHDDH is experiencing some difficulty in obtaining accurate encounter data from the State's Medicaid Management Information System (MMIS). This issue is being addressed through imposition of financial penalties on managed care organizations that exceed a 1% error rate in the data reported to the MMIS

2. The behavioral healthcare on-line database (RIBHOLD) maintains the same data for individuals receiving substance use disorder treatment and mental health services. (For individuals without a co-occurring disorder, certain measures are not applicable, but the items are asked for all clients)

RIBHOLD is used exclusively for behavioral healthcare purposes, including providing Treatment Episode Data Set (TEDS) and basic client information (BCI) to SAMHSA. BHDDH is in the process of transferring the data management system to a new platform which will permit reporting of both data sets through TEDS.

3. BHDDH has the ability to report client-level data to SAMHSA and to utilize these data for internal planning purposes.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Youth
Priority Type: SAP
Population(s): Other (Children/Youth at Risk for BH Disorder)

Goal of the priority area:

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

Objective:

By 9/30/18, decrease the percent of youth (ages 12-17) reporting current and past 30-day use of alcohol, marijuana, prescription drugs, and tobacco products, especially use of electronic nicotine delivery system products (ENDS).

Strategies to attain the objective:

Implementation of an evidence-based program, Project SUCCESS, in junior high/middle schools and high schools in 25 of 35 school districts statewide. Project SUCCESS include programming directed at the entire school population (Universal Indirect); education for an entire grade of students (Universal Direct); and interventions for students at high risk for substance use (Selected and/or Indicated).

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Percentage of youth, ages 12-17, reporting current and 30 day use of alcohol, marijuana, prescription drugs, and tobacco products, especially the use of electronic nicotine delivery system products (ENDS)
Baseline Measurement: 2015 data shows that Rhode Island youth ages 12-17 alcohol use rates in the past month at 26.1%; youth marijuana use rates in the past month at 20.6%; youth prescription drug use rates in the past month at 11.6%, youth cigarette use rates in the past month at 4.8% and ENDS products use rates in the past month at 40.9%.
First-year target/outcome measurement: One percentage point decrease in reported past 30-day use of alcohol, marijuana, prescription drugs, tobacco, and ENDS products by junior high/middle school and high school students in municipalities implementing Project SUCCESS
Second-year target/outcome measurement: Unchanged from Year 1

Data Source:

Rhode Island Student and Youth Risk Behavioral Surveys

Description of Data:

The Rhode Island Student Survey (RISS) is a risk and prevalence survey that is administered bi-annually in nearly every middle and high school. The Youth Risk Behavior Survey is also administered bi-annually on the off year of the RISS to a school sample.

Data issues/caveats that affect outcome measures:

The RISS was administered in 2016 and did not meet the 60% response rate threshold required by our evaluator to consider the survey to be complete and valid. Upon review, it was determined that the presence of a school proctor was essential for successful survey administration. Therefore, proctor training has been developed for the 2018 RISS administration and a process has been put in place to ensure improved communication with both coalition coordinators and school personnel.

Municipal level data is only available from the RISS and the YRBS only provides state estimates; therefore, for the second year when the YRBS will be administered, the measurement will be based on state estimates.

Priority #: 2
Priority Area: Pregnant Women and Women with Dependent Children
Priority Type: SAT
Population(s): PWWDC

Goal of the priority area:

To provide peer recovery support services to pregnant and parenting women with substance use disorders, particularly opioid use disorders, and women receiving medication assisted treatment (MAT).

Objective:

By 9/30/18, train and support an additional cohort of 8 peer recovery support specialists with content area expertise (opioid use disorder, substance use disorder, and child welfare involvement) to work with pregnant and parenting women with substance use disorders to assist them in their recovery and reunification process (if applicable).

Strategies to attain the objective:

1. Provide 2 trainings to increase the number of peer recovery support specialists with lived experience to assist women through pregnancy, birth, and early parenting.
2. Collaborate with the State's Neonatal Abstinence Syndrome (NAS) Task Force to implement its plan to increase access to education, services and treatment for pregnant women and women with dependent children.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	The number of certified peer recovery specialists working with pregnant and parenting women with substance use disorders especially opioid use disorders.
Baseline Measurement:	8 women currently are trained as peer recovery specialists and are working with pregnant and parenting women with substance use disorders.
First-year target/outcome measurement:	4 additional women are working as trained peer recovery specialists with pregnant and parenting women with substance use disorders
Second-year target/outcome measurement:	4 additional (over first year target) women are working as trained peer recovery specialists with pregnant and parenting women with substance use disorders

Data Source:

Governor's Overdose Prevention and Intervention Task Force

Description of Data:

The Governor's Overdose Prevention and Intervention Task Force maintains a dash board for all strategies being implemented which is managed by Brown University and supported with information provided by the Departments of Health and BHDDH.

Data issues/caveats that affect outcome measures::

None

Indicator #:	2
Indicator:	Number of women who receive training as peer recovery specialists to work with pregnant and parenting women with substance use disorders
Baseline Measurement:	8 women currently have received training as peer recovery specialists to work with pregnant and parenting women with substance use disorders
First-year target/outcome measurement:	8 additional women receive training as peer recovery specialists to work with pregnant and parenting women with substance use disorders
Second-year target/outcome measurement:	8 addition women (over first year target) receive training as peer specialist to work with pregnant and parenting women with substance use disorders

Data Source:

Governor's Overdose Prevention and Intervention Task Force

Description of Data:

The Governor's Overdose Prevention and Intervention Task Force maintains a dash board for all strategies being implemented which is managed by Brown University and supported with information provided by the Departments of Health and BHDDH.

Data issues/caveats that affect outcome measures::

None

Indicator #: 3

Indicator: Disbursement of copies of SAMHSA's resource document A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders to substance use disorder treatment and OB/GYN service providers

Baseline Measurement: baseline to be established

First-year target/outcome measurement: Distribute a minimum of 50 copies of SAMHSA's resource document to substance use disorder treatment and OB/GYN service providers

Second-year target/outcome measurement: Distribute a minimum of 50 copies of SAMHSA's resource document to substance use disorder treatment and OB/GYN service providers

Data Source:

State's Neonatal Abstinence Syndrome Task Force

Description of Data:

Number of SAMHSA's resource document distributed

Data issues/caveats that affect outcome measures::

Priority #: 3
Priority Area: Persons Who Inject Drugs
Priority Type: SAT
Population(s): Other ()

Goal of the priority area:

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

Objective:

1. By 9/30/20, all hospitals/emergency departments in RI will have peer recovery specialists available to respond to patients who have experienced a drug overdose.
2. By 9/30/18, establish a pilot program with hospitals/emergency departments to improve client engagement with peer recovery specialist upon discharge following a drug overdose.
3. By 9/30/18, increase the number of communities receiving services from the Mobile Outreach Team from baseline.

Strategies to attain the objective:

1. Collaborate with the RI Department of Health to institute policies at hospitals/emergency departments to ensure availability of peer recovery specialists to respond to patients who have experienced a drug overdose.
2. Pilot a minimum of one program to increase client engagement when leaving the hospital following a drug overdose.
3. Expand mobile outreach services in identified high-incidence communities to support overdose survivors in seeking access to recovery supports through the efforts of the Mobile Outreach Recovery Efforts (MORE) team administered by the Anchor Recovery Center. The MORE team, which includes certified peer recovery specialists, provides outreach services in all of RI's 39 municipalities to increase participation in recovery programs and to connect individuals with treatment services if participants express a willingness to participate in such services. More intensive outreach services are provided in high-incidence communities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of hospitals/emergency departments providing patient access to peer recovery specialists following a drug overdose regardless of route of administration

Baseline Measurement: baseline to be established

First-year target/outcome measurement: Increase the number of hospitals/emergency departments providing patient access to peer recovery specialists following a drug overdose by 1 facility over baseline

Second-year target/outcome measurement: Increase number of hospitals/emergency departments providing patient access to peer recovery specialists following a drug overdose by 1 facility over first year target

Data Source:

BHDDH Community Engagement and Program Services Unit

Description of Data:

Collected through monthly contact with the Anchor Recovery Center.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: Implementation of pilot patient engagement project in a hospital/emergency department in an identified high-incidence community that increases contacts with peer recovery specialist for patients who have overdosed, regardless of route of administration

Baseline Measurement: baseline to be established

First-year target/outcome measurement: pilot one patient engagement project at a Charter Care facility in collaboration with peer recovery specialist provider, Anchor Recovery Center

Second-year target/outcome measurement: Expand project to 2 additional locations pending review of outcomes from initial pilot site

Data Source:

BHDDH Community Engagement and Program Services Unit

Description of Data:

The Community Engagement and Program Services Unit conducts a monthly phone call with Charter Care and the Anchor Recovery Center to implement the pilot project and to discuss progress and/or barriers to successful implementation.

Data issues/caveats that affect outcome measures::

None

Indicator #: 3

Indicator: Number of high-incidence communities receive intensive outreach services from the Mobile Outreach Recovery Efforts (MORE) team

Baseline Measurement: 9 high-incidence communities receiving intensive outreach services from the Mobile Outreach Recovery Efforts (MORE) team

First-year target/outcome measurement: 10 high-incidence communities receive intensive outreach services from the Mobile Outreach Recovery Efforts (MORE) team

Second-year target/outcome measurement: 11 high-incidence communities receive intensive outreach services from the Mobile Outreach Recovery Efforts (MORE) team by 1 over first year target

Data Source:

BHDDH Contract Monitoring Unit

Description of Data:

Monthly reports are collected from providers and on-going BHDDH contract monitoring will inform this indicator.

Data issues/caveats that affect outcome measures::

Priority #: 4
Priority Area: EIS/HIV
Priority Type: SAT
Population(s): EIS/HIV

Goal of the priority area:

Ensure that HIV/AIDS education, testing and treatment is available to all clients of Opioid Treatment Programs (OTPs).

Objective:

1. By 9/30/18, hire one physician specializing in infectious diseases in OTPs to offer education to staff; and to coordinate education, testing and treatment of OTP clients.
2. By 9/30/20, increase the number of OTP clients receiving HIV/AIDS education, testing and treatment coordinated by a physician specializing in infectious diseases by 40% over baseline.

Strategies to attain the objective:

Through implementation of the Ryan White grant, hire an infectious disease physician to provide education to OTP staff; and to coordinate education, screening and treatment of clients in opioid treatment programs.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Employment of a physician specializing in infectious diseases at an OTP
Baseline Measurement: 0
First-year target/outcome measurement: 1 physician hired
Second-year target/outcome measurement: Pending availability of funding, increase number of physicians in OTPs by 1 over first year target

Data Source:

Ryan White grant

Description of Data:

The Ryan White program has a Data Analyst who will inform the Department of progress towards this goal.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2
Indicator: Number of OTP clients receiving HIV/AIDS education, testing and treatment coordinated by a physician specializing in infectious diseases
Baseline Measurement: baseline to be established
First-year target/outcome measurement: 30% increase in the number of OTP clients receiving HIV/AIDS education, testing and treatment coordinated by a physician specializing in infectious diseases

Second-year target/outcome measurement: 40% increase in the number of OTP clients receiving HIV/AIDS education, testing and treatment coordinated by a physician specializing in infectious diseases over baseline

Data Source:

Ryan White grant

Description of Data:

The Ryan White program has a recently-hired Data Analyst who will evaluate progress toward the goal.

Data issues/caveats that affect outcome measures::

Attainment of first- and second-year targets is dependent upon date of hire for the infectious disease physician. A significant delay in hiring the physician may result in fewer than anticipated OTP clients being provided with HIV/AIDS wrap-around services.

Priority #: 5
Priority Area: TB
Priority Type: SAT
Population(s): TB

Goal of the priority area:

To maintain current incidence of active TB cases reported for clients of behavioral health organizations licensed by BHDDH at zero.

Objective:

By 9/30/18, ensure that 100% of behavioral health organizations licensed by BHDDH comply with state rules and regulations and CDC guidelines regarding assessment and treatment of TB.

Strategies to attain the objective:

1. Monitor provider compliance through client record reviews conducted by the BHDDH contract monitoring unit.
2. Review Medicaid claims data for individuals receiving SUD and TB services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of client record review demonstrating behavioral health organization compliance with TB-related regulations and contract language.

Baseline Measurement: 100% of client record reviews demonstrate licensed behavioral health organizations testing and referral to PCP or RISE clinic consistent with state rules and regulations and CDC guidelines

First-year target/outcome measurement: 100% of client record reviews demonstrate licensed behavioral health organizations testing and referral to PCP or RISE clinic consistent with state rules and regulations and CDC guidelines

Second-year target/outcome measurement: 100% of client record review demonstrate licensed behavioral health organizations testing and referral to PCP or to RISE clinic consistent with state rules and regulations and CDC guidelines

Data Source:

BHDDH Contract Monitoring Unit, Independent Peer Review

Description of Data:

Ongoing monitoring by BHDDH Contract Monitoring Unit and review of selected programs by Peer Review Committee.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: Medicaid claims for TB-related codes match with client record reviews and behavioral health service claims data

Baseline Measurement: 100% of Medicaid claims for TB-related codes match with client record reviews and behavioral health service claims data

First-year target/outcome measurement: 100% of Medicaid claims for TB-related codes match with client record reviews and behavioral health service claims data

Second-year target/outcome measurement: 100% of Medicaid claims for TB-related codes match with client record reviews and behavioral health service claims data

Data Source:

BHDDH Contract Monitoring Unit, State Medicaid Management Information System, BHDDH's updated electronic reporting system, RIBHOLD 2.0

Description of Data:

BHDDH Contract Monitoring Unit monitoring reports, Medicaid claims data for TB-related codes cross-referenced with behavioral health service data maintained by RIBHOLD 2.0.

Data issues/caveats that affect outcome measures::

Priority #: 6

Priority Area: Youth, adolescents and young adults with substance use and/or co-occurring disorder.

Priority Type: SAT, MHS

Population(s): Other (Adolescents w/SA and/or MH)

Goal of the priority area:

Increase 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.

Objective:

By 9/30/18, implement Seven Challenges program at 4 sites in RI.

Strategies to attain the objective:

Implement the evidence-based Seven Challenges program which has been shown to produce positive outcomes in reducing substance use and improving mental health status in adolescents.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of sites implementing the Seven Challenges program with fidelity

Baseline Measurement: baseline to be established

First-year target/outcome measurement: Implement Seven Challenges program with fidelity at 4 sites across the State

Second-year target/outcome measurement: Maintaining implementation of Seven Challenges program with fidelity at 4 sites across the the State

Data Source:

State Youth Treatment Implementation grant GPRA

Description of Data:

SAMHSA data collection tool for CSAT discretionary grants.

Data issues/caveats that affect outcome measures::

None

Priority #: 7
Priority Area: ESMI
Priority Type: MHS
Population(s): ESMI

Goal of the priority area:

Ensure youth and young adults (ages 16-25) have access to and utilize behavioral healthcare services.

Objective:

By 9/30/18, increase the number of youth and young adults ages 16-25 who receive behavioral healthcare services through the Healthy Transitions Coordinated Specialty Care evidence-based model by 2 individuals, and by an additional 3 individuals in the following year.

Strategies to attain the objective:

Continue to implement the Healthy Transitions grant at the Labs operated through the Community Care Alliance which provides services to eligible individuals ages 16-25 living in the municipalities of Burrillville, Cumberland, Lincoln, North Smithfield and Woonsocket; and the Kent Center which provides services to eligible individuals ages 16-25 living in the municipalities of Coventry, East Greenwich, Warwick, West Greenwich, and West Warwick.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of youth and young adults ages 16-25 receiving outreach, assessment and treatment services through Healthy Transitions project
Baseline Measurement: 15 youth and young adults receiving services through Healthy Transitions project
First-year target/outcome measurement: 17 youth and young adults receiving services through Healthy Transitions project
Second-year target/outcome measurement: 20 youth and young adults receiving services through Healthy Transitions project

Data Source:

Healthy Transitions GPRA

Description of Data:

SAMHSA data collection tool for CMHS discretionary grants.

Data issues/caveats that affect outcome measures::

None

Priority #: 8
Priority Area: Adults with SMI
Priority Type: MHS
Population(s): SMI

Goal of the priority area:

Reduce unnecessary hospitalization use by Integrated Health Homes/Assertive Community Treatment (IHH/ACT) clients.

Objective:

1. By 9/30/19, reduce emergency department visit rate per 1000 by 3 percentage points for IHH/ACT clients (Ambulatory Care measure AMB-HH).
2. By 9/30/19, reduce hospital re-admission rate per 1000 by 2 percentage points for IHH/ACT clients who were re-admitted to a hospital within 30 days

of a previous admission (Plan All-Cause Re-Admission Measure PCR-HH).

Strategies to attain the objective:

1. Modify the community mental health center contracts to create incentives to reduce unnecessary admissions to hospitals and emergency department use by IHH/ACT clients.
2. Monitor to ensure inclusion of certified peer recovery specialists in IHH teams to engage clients in community supports and to reduce emergency department visits and hospital re-admissions.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Rate of IHH/ACT clients being re-admitted to hospitals within 30 days of previous admission per 1000.

Baseline Measurement: current rate per 1000 is 541 for IHH/ACT members

First-year target/outcome measurement: 540 per 1000

Second-year target/outcome measurement: 539 per 1000

Data Source:

MMIS

Description of Data:

Medicaid claims data for IHH/ACT members

Data issues/caveats that affect outcome measures::

Note that this data is State Fiscal Year; however, going forward, reporting will be shifted to align with the MACPRO (CMS) reporting which is based on the Calendar Year.

Indicator #: 2

Indicator: Rate per 1000 for emergency room visits by IHH/ACT clients

Baseline Measurement: Current rate per 1000 for emergency room visits by IHH/Act clients is 28

First-year target/outcome measurement: 26

Second-year target/outcome measurement: 25

Data Source:

MMIS

Description of Data:

Medicaid claims data for IHH/ACT clients.

Data issues/caveats that affect outcome measures::

Data are for State Fiscal Year. Going forward, reporting will align with the MACPRO (CMS) reporting which is based on the Calendar Year.

Priority #: 9

Priority Area: Homeless

Priority Type: MHS

Population(s): Other (Homeless)

Goal of the priority area:

Provide affordable housing with supportive services to individuals experiencing chronic or long-term homelessness.

Objective:

1. By 9/30/18, 50 individuals experiencing chronic homelessness will be placed in supportive housing.
2. By 9/30/18, SOAR approval rate for individuals experiencing chronic or long-term homelessness will equal the overall state approval rate of 84%.

Strategies to attain the objective:

1. Conduct outreach to individuals experiencing homelessness to determine status of chronic or long-term homelessness, including conducting VI to add individuals to the State's consolidated housing wait list through the HMIS.
2. Perform VI-SPDAT to determine service needs.
3. Participate in the chronic homeless housing wait list work group managed through the statewide Continuum of Care.
4. Engage individuals in supportive services.
5. Implement SOAR.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals who have experienced chronic or long term homelessness that are housed in supportive housing.

Baseline Measurement: 45

First-year target/outcome measurement: 50

Second-year target/outcome measurement: 50

Data Source:

Homeless Management Information System

Description of Data:

The Department of Housing and Urban Development's mandatory data base for the RI Continuum of Care.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: SOAR approval rate for individuals who have experience chronic or long-term homelessness.

Baseline Measurement: 2016 84%

First-year target/outcome measurement: Maintain approval rate 84%

Second-year target/outcome measurement: Maintain approval rate 84%

Data Source:

SAMHSA SOAR OAT data base.

Description of Data:

Provides state data on SOAR approval rates.

Data issues/caveats that affect outcome measures::

Success in increasing the SOAR approval rate has been due primarily to CABHI funds allowing a team to be in place to work on applications. The CABHI grant ends in October 2018 which may affect the State's ability to maintain the approval rate long-term.

Priority #: 10

Priority Area: SMI Older Adults

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Older adults with behavioral health disorders, particularly SMI, have access to behavioral healthcare services at the appropriate level of care.

Objective:

1. By 9/30/18, develop training materials, including diagnostic guidelines for identifying behavioral health disorders, including SMI, in older adults with and without other co-occurring diagnoses such as dementia.
2. By 9/30/18, pilot training of staff at a long-term care facility based on training materials.
3. By 9/30/18, provide training to long-term care facility front-line and clinical staff to improve treatment of residents with behavioral health disorders, especially SMI.

Strategies to attain the objective:

1. In collaboration with the RI Elder Mental Health Coalition (RIEMHAC), research best practices for diagnosing behavioral health and behavioral health/co-occurring conditions in older adult populations and develop training materials based on findings.
2. Implement training of staff at one long-term care facility utilizing training materials.
3. Implement training of front-line and clinical staff at a minimum of one long-term care facility in effective treatment of behavioral health disorders in older adults.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: training materials to support proper diagnosis of behavioral health disorders, especially SMI, in older adults with and without other co-occurring diagnoses such as dementia

Baseline Measurement: baseline to be established

First-year target/outcome measurement: training materials, including diagnostic guidelines developed .

Second-year target/outcome measurement: training materials updated as necessary

Data Source:

RI Elder Mental Health Coalition

Description of Data:

training materials

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: pilot training on proper diagnosis of behavioral health disorders, especially SMI, in older adults with and without other co-occurring diagnoses

Baseline Measurement: to be established

First-year target/outcome measurement: pilot training implemented in one long-term care facility

Second-year target/outcome measurement: training implemented at a minimum of one additional long-term care facility

Data Source:

RI Elder Mental Health Coalition

Description of Data:

training records

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: training of front-line and clinical staff at long-term care facility to improve treatment of older adults with behavioral health disorders, especially SMI

Baseline Measurement: baseline to be established

First-year target/outcome measurement: training of front-line and clinical staff at 1 long-term care facility to improve treatment of older adults with behavioral health disorders, especially SMI

Second-year target/outcome measurement: training of front-line and clinical staff at 1 additional long-term care facility to improve treatment of older adults with behavioral health disorders, especially SMI

Data Source:

RI Elder Mental Health Coalition

Description of Data:

training records

Data issues/caveats that affect outcome measures::

Priority #: 11

Priority Area: Children at risk of BH disorders and their families

Priority Type: MHS

Population(s): Other (Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Maintain children/youth at risk of BH disorders in their home and community or in the least restrictive setting as possible through accessing community based programs and peer support.

Objective:

Parent support organization staff to engage with families and youth not involved with DCYF to increase knowledge about SED and help youth and families develop their own support network .

Strategies to attain the objective:

provide peer support services, education about resources, family public awareness programs and attend Family Team Meetings addressing service needs

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of families with children at risk of BH disorders receiving servies through warm line, visits, meetings, phone calls, workshops, acitivities and conferences

Baseline Measurement: 250

First-year target/outcome measurement: 260 families

Second-year target/outcome measurement: 265 families

Data Source:

MIS system of family support agency, attendance forms, tracking forms

Description of Data:

Basic demographic data including count of type of services received

Data issues/caveats that affect outcome measures::

possible duplication on count of services

Priority #: 12

Priority Area: Children at risk of BH disorders and their families

Priority Type:

Population(s): SED

Goal of the priority area:

Maintain SED children/youth in their home and community or in the least restrictive setting as possible

Objective:

Increase access and use of support services and evidence based and evidence informed community based services

Strategies to attain the objective:

Families with children/youth meeting the criteria for SED receive evidence-based parenting education and /or peer support, educational workshops, support groups

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of families with children meeting criteria for SED receive evidence-based parenting, peer support, educational workshops, support groups

Baseline Measurement: 120

First-year target/outcome measurement: 130

Second-year target/outcome measurement: 140

Data Source:

MIS

Description of Data:

Number of parents served through these services

Data issues/caveats that affect outcome measures::

Confirming the SED

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$7,679,228		\$0	\$10,850,764	\$438,936	\$0	\$0
a. Pregnant Women and Women with Dependent Children**	\$320,674		\$0	\$0	\$0	\$0	\$0
b. All Other	\$7,358,554		\$0	\$10,850,764	\$438,936	\$0	\$0
2. Primary Prevention	\$6,758,046		\$0	\$5,346,992	\$112,000	\$180,000	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
4. Early Intervention Services for HIV	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary							
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
10. Administration (Excluding Program and Provider Level)	\$759,856		\$0	\$1,170,652	\$1,964,610	\$0	\$0
11. SABG Total (Row 1, 2, 3, 4 and 10)	\$15,197,130	\$0	\$0	\$17,368,408	\$2,515,546	\$180,000	\$0

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
3. Tuberculosis Services							
4. Early Intervention Services for HIV							
5. State Hospital			\$0	\$0	\$0	\$0	\$0
6. Other 24 Hour Care		\$0	\$0	\$0	\$0	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$3,333,940	\$0	\$8,667,540	\$0	\$0	\$0
8. Mental Health Primary *		\$0	\$0	\$0	\$0	\$0	\$0
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		\$392,228	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$196,114	\$0	\$1,390,010	\$2,564,014	\$0	\$0
11. MHBG Total (Row 5, 6, 7, 8, 9 and 10)	\$0	\$3,922,282	\$0	\$10,057,550	\$2,564,014	\$0	\$0

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	15562	320
Women with Dependent Children	26047	0
Individuals with a co-occurring M/SUD	29910	6258
Persons who inject drugs	20000	6826
Persons experiencing homelessness	2968	1928

Please provide an explanation for any data cells for which the stats does not have a data source.

Pregnant women: Multiplied the estimated 2010 Census pop. of women ages 19-44 (add all age ranges and multiply by percentage overall female) by the percentage of adults ages 18+ determined to need access to treatment. Assumes that all women ages 20-44 are pregnant; 51.7% of all age ranges on census were female; that pregnant women use at the same rate of general adults; comparing populations from two different time points (2010 and 2015).

Women with Dependent Children: BHDDH does not capture women with dependent children at this time, when we implement the new system we will capture this data. The methodology for the need was to multiply the estimated 2010 Census pop. of women ages 19-60 (add all age ranges and multiply by percentage overall female) by the percentage of adults ages 18+ determined to need access to treatment services (states 5.4M aged 18-25 and 15M aged 26+ need treatment for SUD) according to 2015 NSDUH. Assumes that all women ages 20-59 have dependent children; 51.7% of all age ranges on census are female; that women with dependent children use at the same rate of general adults. COD: For co-occurring the Department does capture co-occurring diagnostics but it is all client self report. We will be using a more rigorous diagnostic code analysis in the new system. Regardless, there are 6,258 individuals out of 10,206 currently receiving SUD treatment that self-reported co-occurring M/SUD. Methodology for estimated need was done by multiplying the estimated 2010 Census pop of all ages 10+ by percentage of youth 12+ who have MED/SUD and adults 18+ who have M/SUD in last year.

Assumed underestimation; does not include any other M other than MDE for youth; ages don't match (10+ for Census and 12+ for NSDUH). Persons who inject drugs: Source: Rhode Island Integrated Prevention & Care Comprehensive and Statewide Coordinated Statement of Need Plan. Author admits estimate likely contains both intravenous and non-intravenous drug users. Homelessness: Understanding need is complicated, by accessing the HMIS

data, we can determine how many people of the 2,689 homeless individuals who received a vulnerability assessment in 2016 agree that they have an SUD (59.7%) and how many were taken to the ER because of emotional issues (50.7%). While there is overlap, there are probably others who are homeless who have not received a vulnerability assessment.

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Expenditure Category	FFY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	\$3,839,614
2 . Primary Substance Abuse Prevention	\$3,379,023
3 . Tuberculosis Services	
4 . Early Intervention Services for HIV *	
5 . Administration (SSA Level Only)	\$379,928
6. Total	\$7,598,565

* For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend SABG funds for EIS/HIV if they chose to

do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Strategy		IOM Target	FY 2018
			SA Block Grant Award
Information Dissemination	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		\$0
Education	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		\$0
Alternatives	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		\$0
Problem Identification and Referral	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		\$0

Community-Based Process	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Section 1926 Tobacco	Universal	\$18,000
	Selective	
	Indicated	
	Unspecified	
	Total	\$18,000
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Total Prevention Expenditures		\$18,000
Total SABG Award*		\$7,598,565
Planned Primary Prevention Percentage		0.24 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

States are required to complete either Table 5a or Table 5b. We completed Table 5b however we completed the portion of 5a that asks about

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity		FY 2018 SA Block Grant Award
Universal Direct		\$856,747
Universal Indirect		\$572,163
Selective		\$1,330,054
Indicated		\$236,655
Column Total		\$2,995,619
Total SABG Award*		\$7,598,565
Planned Primary Prevention Percentage		39.42 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

These planned expenditures are an estimate. The prevention system has undergone a system redesign and providers are in the process of performing new needs assessments that could potentially change the cost allocations. Also, Table 5a reflects Section 1926- Tobacco (Synar Program). Table 4 reflects system development/non-direct.

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Targeted Substances	
Alcohol	b
Tobacco	b
Marijuana	b
Prescription Drugs	b
Cocaine	e
Heroin	b
Inhalants	e
Methamphetamine	e
Synthetic Drugs (i.e. Bath salts, Spice, K2)	e
Targeted Populations	
Students in College	e
Military Families	e
LGBT	e
American Indians/Alaska Natives	e
African American	e
Hispanic	e
Homeless	e
Native Hawaiian/Other Pacific Islanders	e
Asian	e
Rural	e
Underserved Racial and Ethnic Minorities	e

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems	\$91,200		\$25,020	
2. Infrastructure Support				\$416,404
3. Partnerships, community outreach, and needs assessment	\$95,000	\$54,166	\$21,270	
4. Planning Council Activities (MHBG required, SABG optional)	\$41,554			
5. Quality Assurance and Improvement		\$5,000		
6. Research and Evaluation			\$142,114	
7. Training and Education	\$153,000		\$195,000	\$102,000
8. Total	\$380,754	\$59,166	\$383,404	\$518,404

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁵ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁶ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁷

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.²⁸ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁹ For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.³⁰

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³¹ SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³² The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.³³ Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁴ and ACOs³⁵ may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.³⁶ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁷

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁸ Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.³⁹ SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.⁴⁰ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.⁴¹ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴² Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁴³ SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.⁴⁴ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

²⁵ BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:102?123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52?77

²⁶ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁷ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁸ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <http://www.cdc.gov/socialdeterminants/Index.html>

²⁹ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

³⁰ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

³¹ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

³² Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

- ³³ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice--telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>
- ³⁴ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>
- ³⁵ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx
- ³⁶ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>
- ³⁷ What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>
- ³⁸ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>
- ³⁹ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>
- ⁴⁰ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707
- ⁴¹ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218
- ⁴² Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>
- ⁴³ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>
- ⁴⁴ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

BHDDH has implemented Health Homes for persons diagnosed with severe and persistent mental illness (SPMI) and serious mental illness (SMI), as well as, for Opioid Treatment Programs (OTP). The Department collects health outcomes as part of its performance based contracting in cooperation with the Division of Medicaid.

Rhode Island also received a State Innovation Model grant (SIM), which is a multi-year grant (2015-2019) focusing on moving our payment system from volume to value in order to improve our Population and Behavioral Health. Specific goals include improving behavioral health care delivery and integrating behavioral health care into primary care settings, implementing SBIRT in primary care settings, expanding access to pediatric psychiatry services, and using Community Health Teams (CHTs) to deliver components of team-based healthcare and behavioral healthcare. PCMH-Kids builds off a successful adult patient-entered medical home (PCMH) initiative in Rhode Island. PCMH-Kids is extending the transformation of the state's primary care practices to children. PCMH Kids' mission is to engage providers, payers, patients, parents, purchasers, and policy makers to develop high quality family and PCMHs for children and youth that will assure optimal health and development, a commitment to quality measurement, accountability for costs and outcomes, a focus on population health, and dedication to data-driven system improvement.

BHDDH also received a Screening, Brief Intervention and Referral to Treatment (SBIRT) grant into 2017 to provide screening for substance use disorders in high need communities across the state in primary care settings and the Department of Corrections.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

A System Change component is part of the SIM and SBIRT grants mentioned above. A steering committee of high level staff from

the state departments that focus on health and human services, including Medicaid, the Health Insurance Commissioner, Department of Health, Department of Behavioral Healthcare, Developmental Disabilities and Hospital and the Executive Office of Health and Human Services .

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ☒ Yes ☒ No
- and Medicaid? ☒ Yes ☒ No
4. Who is responsible for monitoring access to M/SUD services by the QHP?
BHDDH is working collaboratively with the Office of the Health Insurance Commissioner and the Division of Medicaid on a survey to identify parity issues.
5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ☒ Yes ☒ No
6. Do the behavioral health providers screen and refer for:
- a) Prevention and wellness education ☒ Yes ☒ No
- b) Health risks such as
- i) heart disease ☒ Yes ☒ No
- ii) hypertension ☒ Yes ☒ No
- viii) high cholesterol ☒ Yes ☒ No
- ix) diabetes ☒ Yes ☒ No
- c) Recovery supports ☒ Yes ☒ No
7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ☒ Yes ☒ No
8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ☒ Yes ☒ No
9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?
We are currently in the analysis process. Our managed care organizations responsible for Medicaid have pushed back a little on completing the state requested analysis documents. The commercial side is being assessed by a paid private analyst and is moving along.
10. Does the state have any activities related to this section that you would like to highlight?
BHDDH, the Office of the Health Insurance Commissioner and Department of Health are participating in a SAMHSA sponsored policy academy on parity. They team is in the process of completing a survey of both the private insurers and Medicaid and the Managed Care Organizations. The group is looking at financial requirements and treatment limitations. They are creating action plans and a communication plan to make health plans and individuals aware of their rights relating to parity.
Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁴⁵, [Healthy People, 2020](#)⁴⁶, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁷, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)⁴⁸.

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁴⁹

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status⁵⁰. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations⁵¹. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

⁴⁵ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴⁶ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁷ <http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁴⁸ <http://www.thinkculturalhealth.hhs.gov>

⁴⁹ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁰ <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵¹ http://www.whitehouse.gov/omb/fedreq_race-ethnicity

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?
 - a) Race ☒ Yes ☒ No
 - b) Ethnicity ☒ Yes ☒ No
 - c) Gender ☒ Yes ☒ No
 - d) Sexual orientation ☒ Yes ☒ No
 - e) Gender identity ☒ Yes ☒ No
 - f) Age ☒ Yes ☒ No
2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ☒ Yes ☒ No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ☒ Yes ☒ No
4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ☒ Yes ☒ No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard? ☒ Yes ☒ No
6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? ☒ Yes ☒ No
7. Does the state have any activities related to this section that you would like to highlight?

BHDDH is in the process of upgrading its data system to allow for the collection of this critical data. The system is scheduled to come on line in January 2018

BHDDH has been working with the ATTC on implementing a CLAS monitoring tool both internally and externally.

DCYF has a system in place to track access to services and placements that provides information on disparities and disproportionality of service use and outcomes.

Please indicate areas of technical assistance needed related to this section

This may be an area where additional TA is required.

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, ($V = Q ? C$)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁵², The New Freedom Commission on Mental Health⁵³, the IOM⁵⁴, and the NQF⁵⁵. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁵⁶ SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series ([TIPS](#))⁵⁷ are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation ([KIT](#))⁵⁸ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

⁵² United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁵³ The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁵⁴ Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

⁵⁵ National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵⁶ <http://psychiatryonline.org/>

⁵⁷ <http://store.samhsa.gov>

⁵⁸ <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? j n Yes j n No
2. Which value based purchasing strategies do you use in your state (check all that apply):
 - a) ☒ Leadership support, including investment of human and financial resources.
 - b) ☒ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c) ☐ Use of financial and non-financial incentives for providers or consumers.
 - d) ☒ Provider involvement in planning value-based purchasing.
 - e) ☐ Use of accurate and reliable measures of quality in payment arrangements.
 - f) ☒ Quality measures focus on consumer outcomes rather than care processes.
 - g) ☒ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
 - h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

Does the state have any activities related to this section that you would like to highlight?

The state has an evidence based practice work group that primarily focuses on prevention, however, will begin to look at treatment. RI adopted the Integrated Health Home and Opioid Treatment Program Health Home. Through the CCBHC Planning grant the Department worked closely with providers, advocates and consumers to look at payment models. The state is in the process of implementing a quality of care process evaluation to improve fidelity to ACT and ensure our integrated health homes and POT-HH are implemented appropriately.

Please indicate areas of technical assistance needed related to this section.

This is an area where the state is in the process of getting technical assistance, however, depending on the outcome we may need more.

Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode ([RAISE](#)) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ☒ Yes ☐ No

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? ☒ Yes ☐ No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

Through the Healthy Transitions grant the state is piloting Coordinated Specialty Care in 2 community mental health centers.

The RI HT Coordinated specialty care (CSC) is a recovery-oriented treatment program for people who have or are at risk of having a serious mental illness, including first episode psychosis (FEP). CSC promotes shared decision making and uses a team of specialists who work with the client to create a personal treatment plan. The specialists offer psychotherapy, medication management geared to individuals with FEP, family education and support, case management, and work or education support, depending on the individual's needs and preferences. The client and the team work together to make treatment decisions, involving family members as much as possible. The goal is to link the individual with a CSC team as soon as possible after psychotic symptoms begin.

"CSC" is a general term used to describe a certain type of treatment for FEP. There are many different programs that are considered CSC. In the United States, examples of CSC programs include (but are not limited to) NAVIGATE, the Connection Program, OnTrackNY, the Specialized Treatment Early in Psychosis (STEP) program, and the Early Assessment and Support Alliance (EASA). RAISE is not a CSC program. RAISE is the name of a research initiative developed and funded by NIMH to test CSC programs. (The two programs tested by the RAISE initiative were NAVIGATE and the Connection Program.)

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

The state is in the process of implementing a communication plan that addresses stigma based on the "Above of Neck" strategy.

The 2 community mental health centers that are implementing Health Transitions have flyers and a social media strategy to spread

the word about the program. The Healthy Transitions grant also has a youth coordinator who is working with youth and young adults to establish Youth Voice in RI.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI? ☒ Yes ☒ No

5. Does the state collect data specifically related to ESMI? ☒ Yes ☒ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ☒ Yes ☒ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Healthy Transitions RI uses the EBP, Coordinated Specialty Care, to provide developmentally appropriate services to youth and young adults aged 16-25, to identify and address mental health and substance use issues early to mitigate long-term physical and psychological damages. The model uses a team approach to services and supports in community based settings which are identified through a shared decision making model. The youth/young adults are actively engaged in treatment planning and treatment. Services and supports identified include case management, individual or group psychotherapy, supported employment and education services, family counseling/education/support, nursing services, psychiatric evaluation, and medication management.

At its core, CSC is a collaborative, recovery-oriented approach involving participants, treatment team members, and when appropriate, relatives, as active participants. Treatment plans address the unique needs, preferences, and recovery goals of individuals with or at risk of SMI or FEP. Services are highly coordinated with primary medical care, with a focus on optimizing a participant's overall mental and physical health.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

RI plans to continue to implement the HT grant through available federal funding opportunities. These funds are available through 2018 and may be available through 2019. We are working on activities to sustain implementing CSC post grant funding. Question 9: Currently, the set aside is given to the two Healthy Transition Pilot programs. The data collected for Healthy Transitions includes NOMs data reported to SPARS as well as local evaluation data. Local evaluation data includes service delivery and outcome measures. The local evaluation workgroup is starting to analyze and report on outcome and program fidelity measures.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

The state is currently using the data collected through the Healthy Transitions GPRA reported through the SPARS.

10. Please list the diagnostic categories identified for your state's ESMI programs.

RI's Healthy Transition programs provide services and supports to youth and young adults who have or at risk of having a serious mental illness or first episode psychosis. Diagnostic categories include: Schizophrenia spectrum and other Psychotic disorders, Bipolar, Depressive, Anxiety, Obsessive Compulsive, Trauma and stress related, Dissociated

Does the state have any activities related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed related to this section.

Not at the moment.

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? j n Yes j n No
2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
The State has guidance described in question 4.
3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.
The Department implements Health Homes focuses on care coordination and integrating primary care and psychiatric care and provides the framework for consumers and families to make health care decisions.
4. Describe the person-centered planning process in your state.
The State of Rhode Island believes that Person-centered planning strives to place the individual at the center of decision-making. It is based on the values of human rights, interdependence, choice and social inclusion, and can be designed to enable people to direct their own services and supports, in a personalized way. Person-centered planning isn't one clearly defined process, but a range of processes sharing a general philosophical background, and aiming at similar outcomes.

Furthermore, person centered planning is also a process directed by an individual, with impartial assistance when helpful, focusing on their desires, goals, needs, and concerns to develop supports to live a meaningful life maximizing independence and community participation.

Values and Principles of Person Centered Planning:

Person-centered planning is an individualized approach to planning that supports an individual to share his or her desires and goals, to consider different options for support, and to learn about the benefits and risks of each option. Although the process must be customized differently for each person, the following guidelines summarize universally accepted "operating principles" for person-centered planning:

1. The individual is the focus of the planning process and involved in decision making at every point in the process, including deciding how and where planning will take place. Decisions made in the planning process can be revisited whenever the person wants.
2. The individual decides who to invite to the planning team. Planning teams include those who are close to the person, as well as people who can help to bring about needed change for the person and access appropriate services.
3. Planning team members help to identify and foster natural supports. Natural supports include family, friends, community connections, and others in the person's social network. Development of natural supports is encouraged by inviting family members, friends, and allies to participate in planning meetings.
4. The planning team explores informal and formal support options to meet the expressed needs and desires of the individual. Informal supports—family, friends, neighbors, church groups, and local community organizations—are considered first. These natural supports are supplemented by formal services, including services such as personal care services, adult day services, residential services, home care services, nursing services, Meals on Wheels, and caregiver supports.
5. The individual has the opportunity to express his/her needs, desires, and preferences and to make choices. Appropriate accommodations should be made to support the individual's meaningful participation in planning meetings.

6. Some individuals may require assistance in making choices about their individual plans and their supports and services. In these

cases, the individual still participates in the person-centered planning process and makes all decisions that are not legally delegated to a guardian or other substitute decision maker.

Decision Making Process is defined as:

A. Competency – every person is competent to develop their plan, unless a court has determined otherwise, in which case the person should still direct the planning as much as possible with proper support or accommodations.

B. Supported Decision Making : When appropriate, an individual will be supported to the extent necessary to make decisions and direct the planning process.

C. Substituted Judgment : When an individual has been appointed a guardian by a court, the individual should continue to direct the plan with appropriate supports, and the guardian should use a “substituted judgment” standard only when necessary.

D. Best Interest : at no time should the “best interest of” standard be used when developing a person centered plan.

7. The process shifts power and budgeting to the individual with proper support when necessary or requested.

8. The process develops real choice for the individual, not only options of currently available programs.

9. Communications by the individual, including non-verbal communication such as expression, behavior, and mood are considered and respected.

Does the state have any activities related to this section that you would like to highlight?

BHDDH is doing quality care review of all IHH and ACT teams.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? ☒ Yes ☐ No
2. Are there any concretely planned initiatives in our state specific to self-direction? ☒ Yes ☐ No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

- a) How is this initiative financed?
- b) What are the eligibility criteria?
- c) How are budgets set, and what is the scope of the budget?
- d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

BHDDH has an extensive peer recovery specialist certification process that is contracted to the Parent Support Network (PSN). The certification allows for participants to specialize in areas including justice involved, mental health, substance use disorders, homelessness, and pregnant and parenting women with a substance use/opioid use disorder. Medicaid has requested that peer recovery specialist be a billable Medicaid services through a state plan amendment and the state is currently awaiting an answer from CMS. Peer Recovery Specialists are part of the Health Home teams. Block Grant funds pay for recovery centers that are operated by peers and the centers are now providing services to individuals who overdose through outreach in "hot spots" and in the emergency departments.

The state is in the process of receiving technical assistance regarding best practices for supervision of peer recovery specialists.
- e) What, if any, research and evaluation activities are connected to the initiative?

There is currently no evaluation process for the peer recovery specialist program, however, funding was obtained through another source to start and evaluation of this program. The hope is to begin the evaluation in January.
- f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

Presently the state is working on home and community based services planning to incorporate person centered planning. A future initiative could include self direction.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

This would be an area of interest for technical assistance.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ☒ Yes ☐ No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? ☒ Yes ☐ No

Does the state have any activities related to this section that you would like to highlight?

The Contract Monitoring unit oversees how federal dollars are spent and ensures compliance with their intended use.

Please indicate areas of technical assistance needed to this section

Technical assistance regarding examples from other states would be helpful.

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁵⁹ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

⁵⁹ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
2. What specific concerns were raised during the consultation session(s) noted above?

Does the state have any activities related to this section that you would like to highlight?

DCYF: Rhode Island has only one Federally Recognized Tribe, the Narragansett Tribe. The Narragansett Tribe does not operate its own child welfare system and relies on the Department to assist with all of the aspects of this State's child welfare auspices. The Department has an internal Policy (#700.0170 attached) reflective of the Federal Indian Child Welfare Act (ICWA). DCYF Administrators and the Narragansett Tribe representatives have agreed that DCYF would use its Policy relating to ICWA as a basis for a State-Tribe agreement. This policy addresses critical considerations relating to:

- Identification of Indian children;
- Notification of Indian parents and Tribes of State proceedings involving Indian children and their right to intervene;
- Special placement preferences for Indian children;
- Active efforts to prevent breakup of the Indian family; and
- Tribal right to intervene in State proceedings.

As such, this Policy represents the understanding between the Department and the Tribe as it relates to the responsibility for providing protections for Tribal children who are in state custody, as referenced in Section 422(b). In addition the Department is also responsible for the following services and protections:

- Operation of a case review system for Narragansett affiliated children in foster care (Administrative Review Unit bi-annually)
- A pre-placement and preventative services program for Narragansett affiliated children at risk of entering foster care to remain safely with their families (Family Care Community Partnerships)
- A service program (Partners in Permanency) for Narragansett affiliated children in foster care to facilitate reunification with their families, when safe and appropriate, or to place a child in an adoptive home, legal guardianship or other planned permanent

living arrangement

- Training for staff on Child and Family Services Improvement and Innovation Act of 2011 and how to conduct credit checks for Narragansett affiliated youth in their caseloads.

Department staff had multiple meetings with Wenonah Harris, Director of Child and Family Services for the Narragansett Indian Tribe, and Anemone Mars to discuss ongoing relations over FFY 16. Most of these meetings were at the Narragansett Longhouse in Charlestown, RI. These meetings were used to discuss various topics, including the draft APSR, compliance with ICWA, training and the CFCIP/ETV.

Ms. Harris raised no concerns about the Department's practices and compliance with ICWA. To continue to improve practice, the Department has formed a workgroup made up of MIS, Legal, Policy and Special projects to assess the new ICWA Regulations and ensure the Department is in compliance and continues to assess itself. We are also looking into making adjustments on RICHIST enhancements. The Department will include Ms. Harris in these discussions.

The Department will continue its collaborative efforts with the Narragansett Tribe throughout this new five-year Child and Family Service Plan. The services and supports that are provided to youth in the Department's care through the Chafee Foster Care Independence Program (CFCIP) are inclusive of Indian youth. A final copy of this APSR will be provided to the Narragansett Tribe upon approval.

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

9. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? ☒ Yes ☐ No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) ☒ Yes ☐ No
 - ☐ Data on consequences of substance using behaviors
 - ☐ Substance-using behaviors
 - ☐ Intervening variables (including risk and protective factors)
 - ☐ Others (please list)
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
 - ☐ Children (under age 12)
 - ☐ Youth (ages 12-17)
 - ☐ Young adults/college age (ages 18-26)
 - ☐ Adults (ages 27-54)
 - ☐ Older adults (age 55 and above)
 - ☐ Cultural/ethnic minorities
 - ☐ Sexual/gender minorities
 - ☐ Rural communities
 - ☐ Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- ☐ Archival indicators (Please list)
- ☒ National survey on Drug Use and Health (NSDUH)
- ☐ Behavioral Risk Factor Surveillance System (BRFSS)
- ☒ Youth Risk Behavioral Surveillance System (YRBS)
- ☐ Monitoring the Future
- ☐ Communities that Care
- ☒ State - developed survey instrument
- ☐ Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds?

☒ Yes ☐ No

If yes, (please explain)

The State Epidemiological Outcomes Workgroup (SEOW) is administered by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), the single state authority for substance abuse prevention and treatment and the state mental health authority and reports results of its activities to the Rhode Island Governor's Council on Behavioral Health. In 2006, the SEOW was established as part of the Strategic Prevention Framework State Incentive Grant (SPF SIG), within the Executive Office of Health and Human Services (EOHHS) and was transferred from EOHHS to BHDDH in 2008. The mission of the SEOW is to institutionalize data-driven planning and decision making for the purposes of state and community level 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.

BHDDH determines funding priorities and allocations based on the SEOW State and Community Profiles.

If no, (please explain) how SABG funds are allocated:

Does the state have any activities related to this section that you would like to highlight?

The SEOW utilizes national and local data drawn from a variety of sources and include 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 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.

BHDDH administers the RI Student Survey Bi-Annually. One notable accomplishment is the collaboration between the RI Department of Health (RIDOH) and BHDDH. We have consulted with the RI DOH and have included relevant tobacco related questions in the survey. Through a cooperative agreement we share the raw RISS data with RIDOH. This has provided city and town specific information that has assisted in their ability to successfully apply for the Tobacco Control Competitive Grant.

Please indicate areas of technical assistance needed related to this section

Sustainability for continuation of the work of our State Epidemiological Outcomes Work group beyond the conclusion of the SPF PFS Grant in 2018.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? j n Yes j n No

If yes, please describe

The Rhode Island Certification Board (RICB) defines a baseline standard for all credentials offered. BHDDH worked with the RICB in order to develop an entry level certification to meet the needs of our prevention coalition staff who are newly entering the prevention field or who work on a part-time basis. The Associate Prevention Specialist (APS) requires less educational and job experience hours. This has increased our workforce and its ability to get certified. Certification continues to be an important component of work workforce development of substance abuse prevention providers. Certification in the field of substance abuse prevention is based on knowledge in six performance domains that ate designed to help the workforce prevent or reduce the conditions that place individuals at increased risk of substance misuse related issues. Workforce development is important because it strives to ensure that the workforce has the same high capacity and competency in delivering prevention services across different communities.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? j n Yes j n No

If yes, please describe mechanism used

The state contracts with a vendor to provide ongoing training and technical assistance through The Rhode Island Prevention Resource Center (RIPRC) is a statewide, central information sharing and training and technical assistance (TTA) resource for all Rhode Island state and community-based substance abuse prevention services and their community partners. In order 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 provided needs assessment surveys and a total of sixteen (16) providers completed the needs assessment 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 of January 2017, RI moved to a regional prevention service delivery model. The needs assessment assessed needs 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%)

The needs assessment also collected data regarding technical assistance content areas in general and technical assistance content areas directly related to regionalization. The five (5) primary findings around general technical assistance include:

- ? How to Increase the Prevention Expertise of Coalition Members (50%)
- ? Maximizing Social Media Tools for Prevention (43%)
- ? How to Engage Key Stakeholders (36%)
- ? Recruitment of Coalition Members for Specific Sectors (29%)
- ? Developing Sustainable Plans (29%)

The five (5) primary findings around technical assistance related to regionalization include:

- ? Recruiting and Maintaining Coalition Members (44%)
- ? Change Management Process (38%)
- ? Refocusing Negative Talk (38%)
- ? Redefining Roles and Responsibilities (31%)
- ? Maintaining and Fostering Networking Relationships (31%)

The training offered also meets the certification requirements and document the number of hours toward certification domains on each certificate of completion provided by the RIPRC. In response to the Key Informant finding and the most recent needs assessment, the RIPRC supported the RIBC to develop the minimum standards for an advanced certification credential. The RICB approved the recommendation and the credential will go into effect January of 2018

The current Prevention Specialist Job description identifies six performance domains and associated tasks for the IC&RC Prevention Specialist Examination. These are described in the IC&RC Prevention Specialist Candidate Guide found at http://www.ricertboard.org/uploads/2/4/5/3/24535823/ps_candidate_guide_4-15.pdf

STRATEGIC PLANNING AND WORKFORCE DEVELOPMENT

BHDDH embarked on a robust strategic planning process in 2016. The state engaged the Governor's Council on Behavioral Health's Prevention Advisory Committee (PAC) to actively participate in developing BHDDH's Strategic Plan. In January of 2017, the state instituted a new prevention service delivery system and the plan was revised to include the regional model.

WORKFORCE DEVELOPMENT ACTION STEPS:

An essential action step is to increase the availability of training to support increased certification and recertification rates among prevention providers. Certification of prevention providers helps to ensure that the workforce has a core set of competencies to effectively work within the prevention and mental health promotion system. Continuing to ensure trainings are available and are tied to core certification domains helps to increase these core competencies. Also, training and technical assistance opportunities should include targeted curricula to address the specific needs of more advanced professionals, such as continuing education requirements of the Certified Prevention Specialist and instituting the new Advanced Certification Specialist credential.

Based on the most recent Rhode Island prevention provider needs assessment, 73% (11/15) of providers who completed the survey and answered this question have completed some level of prevention certification, with 27% (4/15) having completed certification at the Prevention Specialist Supervisor level. Additionally, 57 % (8/14) of providers who completed the survey and answered this question are in the process of applying for certification. We understand staff turn-over and staff retention challenges may contribute to delays in fulfilling the certification requirements. Consider results from the 2014 and most recent needs assessment surveys. In 2014, 28% (9/32) of survey participants reported having been in their current position for 0-3 years, compared to 47% (7/15) in 2017.

I. Increase the utilization of RIPRC TTA services. TTA are critical components of workforce development. Available and accessible TTA are key in this area. The identification of strategies towards implementation of both in-person and online TTA will help to increase potential utilization across multiple training modalities

In the 2015 report, BHDDH proposed increasing the number of funded prevention organizations who participated in RPRC training from 90% to 100% by July 30, 2016. We are pleased to report continue to achieve this goal and have expanded participation to additional behavioral health providers, including: recovery supports, other training providers, mental healthcare providers, adult and youth treatment providers, non-funding community providers and RI Department of Health staff. See chart below for training services offered in year 5.

In an effort to support new prevention providers the RIPRC is in the process of developing a prevention orientation guide. The guide will be released for distribution in July of 2017. The RIPRC is committed to providing training supports across the IOM continuum. To that end, the RIPRC collaborated with the state's treatment training provider to offer skills based training for recovery and treatment providers.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ☒ Yes ☐ No

If yes, please describe mechanism used

BHDDH performs a Request for Proposals (RFP) procurement process. Our prevention providers are required to submit a formal application to request funds. Our technical review team performs an evaluation of the proposal scoring each section and requiring that they follow the steps of the Strategic Prevention Framework (SPF) which include:

Step 1: Assess Needs
Step 2: Build Capacity
Step 3: Plan
Step 4: Implement
Step 5: Evaluation

All applicants are required to demonstrate the stability of their organization, effective management and administrative performance including: Evidence of organizational structure: overall mission, program, and services, indicating how they relate to the goals and priorities described in the RFP. Describe resources, management, and fiscal capabilities sufficient to implement the proposed project and provide accountability that supports or complements the services in this RFP.

Does the state have any activities related to this section that you would like to highlight?

A certification exam guide was developed and distributed to prevention providers. It's also posted on the RIPRC, BHDDH, RICB and national IC&RC websites, http://www.riprc.org/wp-content/uploads/2016/03/PreventionCertificationStudyGuide_12.17.15.pdf. In addition to supporting the state's prevention workforce, the guide continues to be accessed and utilized across the country.

Please indicate areas of technical assistance needed related to this section

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? ☒ Yes ☐ No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

BHDDH embarked on a robust strategic planning process in 2016. The state engaged the Governor's Council on Behavioral Health's Prevention Advisory Committee (PAC) to actively participate in developing BHDDH's Strategic Plan. BHDDH utilizes a multi-year strategic planning process to set substance prevention priorities throughout the state. In January of 2017, the state instituted a new prevention service delivery system and the plan was revised to include the regional model. The Regional Prevention Task Force (RPTF) coalitions will create a regional work plan which will describe the 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 will draw 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, provided support tools for assessment of community needs and resources. Each municipality will select a set of evidence informed or evidence based practices that is congruent with the culture and context of their community We also include a comprehensive section in the Plan on our student assistance services. The Prevention Strategic Plan has been included as an attachment.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ☒ Yes ☐ No ☐ N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- a) ☒ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- b) ☒ Timelines
- c) ☒ Roles and responsibilities
- d) ☒ Process indicators
- e) ☒ Outcome indicators
- f) ☐ Cultural competence component
- g) ☐ Sustainability component
- h) ☐ Other (please list):
- i) ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary ☒ Yes ☐ No

prevention funds?

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ☒ Yes ☐ No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The Evidence Based Practices Workgroup is being convened under the auspices of the Governor's Council on Behavioral Health's Prevention Advisory Committee to: (1) develop guidelines for ascertaining whether a given practice, policy or program meets existing standards for evidence based practice in behavioral health; and (2) identify a process by which an innovative or locally developed behavioral health practice, policy or program can be designated as an evidence based practice in RI. An Evidence Based Practices Workgroup is required under SAMHSA's Partnership for Success (PFS) Initiative and while the initial focus of the group is to perform the two tasks described above as it relates to the PFS, the members intend expand its' work to include a broader behavioral health focus and include the entire continuum of care. The membership of the group is drawn from various behavioral health disciplines and includes but is not limited to service providers, researchers, epidemiologists and consumer advocates. The group has been meeting at least a quarterly since October of 2014.

Does the state have any activities related to this section that you would like to highlight?

Several items to highlight for the Evidence-Based Workgroup are:

2016: Major accomplishments to date have included providing guidance on types or levels of evidence based practice; identifying various sources of evidence based practices, policies and programs; suggesting resources that can be used to help locate peer reviewed literature that can be additional source of applicable apply to innovative or locally developed programs or practices that would seek designation as evidence based in RI; resources to help providers identify the level of evidence applicable to their interventions; development of a draft application package; and identification of pool of content area experts who can participate in a review of an application to be recognized as evidence based and can provide feedback on the applicability of the guidance across behavioral health disciplines and the continuum of care.

2017: The application has been presented in an advanced draft form to multiple BHDDH units, the Prevention Advisory Council (a subset of the Governor's Council), and the Governor's Council on Behavioral Healthcare for comments. A meeting with other northeast behavioral health departments on how they apply a similar process in their states is scheduled for mid July. It is the hope of the workgroup that this application will be ready for implementation by the close of this year.

Please indicate areas of technical assistance needed related to this section.

Sustainability of the Evidence- Based Workgroup beyond the conclusion of the SPF PFS Grant in 2018.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- a) ☐ SSA staff directly implements primary prevention programs and strategies.
- b) ☒ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- c) ☒ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- d) ☒ The SSA funds regional entities that provide training and technical assistance.
- e) ☒ The SSA funds regional entities to provide prevention services.
- f) ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- g) ☐ The SSA funds community coalitions to provide prevention services.
- h) ☐ The SSA funds individual programs that are not part of a larger community effort.
- i) ☐ The SSA directly funds other state agency prevention programs.
- j) ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

The Regional Prevention Task Force (RPTF) coalitions develop and plan health fairs, media campaigns, brochure, resource directories, Public Service Announcements. One particularly successful state wide event is National Drug Take Back. Drug Take Back events are held in many communities throughout the state twice annually and launched with a press conference to gain additional exposure.. It is one way to inform the general public of the need to clean out medicine cabinets. The rates of prescription drug abuse are alarmingly. We know that most youth get their prescription medicines from a family member or friend, including the home medicine cabinet, and often without their knowledge. There are permanent drug drop off boxes in most the our Rhode Island police departments. We are getting the message out that this is the safest way to dispose of unused medications. A number of coalitions have implemented a count it, lock it drop it campaign targeting prescription and over the counter medicine to ensure that they are secure and limit access to family members.

The political landscape in Rhode Island has shifted to consider legalization of recreational use of marijuana. Several RPTF have launched a marijuana media campaign called "the cost is too high" that describes how marijuana affects driving.

learning and that it is addictive. This has been an effective mechanism to educate lawmakers, parents, youth and school personnel about the dangers of youth marijuana use.

We recognize that underage drinking is at a high rate in Rhode Island. Social norm campaigns have been a useful mechanism to disseminate our data to inform students of the percentage of classmates who do not drink alcohol. This is done in creative ways with posters, game challenges and other activities to engage youth to participate.

b) Education:

RPTF coalitions are in the process of performing a needs assessment to determine the specific evidence based classroom, small group sessions, parenting/family classes, education programs that they will use for the youth within their communities. Several coalitions that were previously funded by BHDDH under the Reducing Marijuana and Other Drugs Initiative have continued to implement their evidence based programs within their schools such as: Towards No Drug Use, Life Skills, Too Good by institutionalizing the curriculum through the health teachers.

c) Alternatives:

RPTF coalitions provide constructive and healthy activities that exclude alcohol, tobacco, and other drug use: e.g. drug-free social and recreational activities. Several RPTF coalitions have strong Students Against Destructive Decision- Making groups that serve as a support for students who wish to remain substance free. SADD holds after school and weekend activities such as organizing participation in a local county fair to inform the public of the dangers of substance misuse. Pre-prom and post prom events are held to provide a social event that is substance free.

d) Problem Identification and Referral:

Rhode Island Student Assistance Services (RISAS) is the primary provider for student services. 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 modeled on 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 contracts 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.

Project Success utilizes a combinations of interventions, which include the following:

- The Prevention Education Series- an Alcohol, Tobacco and Other Drug prevention program conducted by a Student Assistance Counselor (SAC) with small groups of students i
- Individual and Group Counseling- Student Assistance Counselors conduct time limited individual and group sessions at school with students, There are ten different counseling groups for students to participate.
- Parent Programs- Student Assistance Counselors include parents as collaborative partners in prevention through parent educations programs.
- Referral- Students and parents who require treatment, more intensive counseling or other services are referred to appropriate community based agencies or practitioners by their SAC.
- School-wide Awareness Activities- conducted monthly with student participation to influence attitudes and norms about substances and related high risk behaviors.

e) Community-Based Processes:

RPTF coalitions organize systemic planning, community team-building, multi-agency coordination/collaboration, community and volunteer training, assessing service and funding. One example of community based process is monthly municipal coalition meetings are held that include stakeholders across the six core sectors, behavioral health foci and continuum of care

- o Business
- o Education
- o Safety
- o Medical/health
- o Government
- o Community/family supports

The focus of the municipal coalition meetings are to develop a multi-year municipal prevention plans and to develop annual work plans detailing the approach described in the municipal prevention plan.

f) Environmental:

RPTF coalitions establish/changes to community standards, codes, and attitudes: e.g. school drug policies, product pricing, social norms, and technical assistance to maximize local enforcement. Nearly all of the RPTF coalitions assist development of school policies that prohibit substance use or bullying on school property. Coalitions implement tobacco

control programs such as retail licensing and other restrictions. We also perform the Alcohol Purchase Survey annually. The Annual Alcohol Purchase Survey (APS) is a key component of RI's effort to reduce underage alcohol use. The results of the APS are used to assess retailer compliance with RI's statutes prohibiting the sale or distribution of alcohol products to individuals under the age of 21; regular enforcement of the statutes is designed to reduce commercial access to alcohol products by underage youth. Such compliance investigations have been shown to be one of the most effective strategies in limiting retail access to alcohol and therefore help to reduce underage alcohol use. Rhode Island's protocol and guidance for conducting underage alcohol purchase investigations. RPTF coalitions assist in the collaboration of municipal police departments as well as the recruitment of underage inspectors for both the APS and Sytar tobacco inspections.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? ☒ Yes ☒ No

If yes, please describe

BHDDH performs a Request for Proposals (RFP) procurement process. Our prevention providers are required to submit a formal application to request funds. Our technical review team performs an evaluation of the proposal scoring each section ensuring that primary prevention activities are included and that they are a proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles. Our providers are required to perform primary prevention activities that include interventions, occurring prior to the initial onset of a substance use disorder, through 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. Each Regional Prevention Task Force demonstrates that programming and funding will cover five of six services areas delivered within their region.

Does the state have any activities related to this section that you would like to highlight?

The BHDDH prevention system has consisted of three major components: municipal task forces (coalitions), student assistance programs established by legislation; and community-based programs, largely curricular in nature, all funded with federal dollars.

The municipal task forces (coalitions) were enacted by the Rhode Island Substance Abuse Prevention Act (RISAPA) legislation in 1987. The Rhode Island General Assembly passed the Rhode Island Substance Abuse Prevention Act (RISAPA) RI General Laws 16-21 to promote comprehensive prevention programming at the community level. In the last year Rhode Island has revitalized the system for prevention. We have a newly composed regional prevention coalition design which has broken the state up into 7 regions. The Regional Prevention Task Forces (RPTF) are primarily responsible for overseeing the planning and delivery of prevention activities within the municipalities that comprise the region. The regional coalition is comprised of multiple municipal substance abuse prevention coalitions who will retain their individual identity and continue to provide prevention services to their communities. The newly-developed regional prevention coalition design provides administrative oversight, funding and other human, technical or financial resources needed to support municipal task force contributions to a regional prevention plan, and it will act as the fiduciary and administrative agent.

The RPTF are funded for 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) 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) 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).

Over the next five years the RPTF will use funding will be assessing our community substance abuse prevention needs and resources, developing a capacity building plan to address any gaps in resources or community readiness and a local strategic plan, implementing evidence based and best practice interventions based on community needs, and evaluating the impact of our efforts.

Please indicate areas of technical assistance needed related to this section.

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? ☒ Yes ☐ No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

BHDDH works with the University of Rhode Island's Community Research and Services Team in the development of a process and outcome evaluation plan across prevention services including the training and technical assistance service vendor.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- a) ☒ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- b) ☐ Includes evaluation information from sub-recipients
- c) ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- d) ☒ Establishes a process for providing timely evaluation information to stakeholders
- e) ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- f) ☐ Other (please list:)
- g) ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- a) ☒ Numbers served
- b) ☒ Implementation fidelity
- c) ☐ Participant satisfaction
- d) ☒ Number of evidence based programs/practices/policies implemented
- e) ☒ Attendance
- f) ☒ Demographic information
- g) ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- a) ☐ 30-day use of alcohol, tobacco, prescription drugs, etc
- b) ☐ Heavy use
 - ☐ Binge use
 - ☐ Perception of harm
- c) ☐ Disapproval of use
- d) ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e) ☐ Other (please describe):

Footnotes:

State of Rhode Island



Final

Strategic Plan for Substance Abuse Prevention 2016-2019

SECTION 1 - INTRODUCTION

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is the single state authority for substance abuse prevention and treatment. BHDDH and key stakeholders, who have a vested interest in prevention, have collaborated to develop the following strategic prevention plan. The purpose of this plan is to outline BHDDH's primary goals and strategies to strengthen the infrastructure and to provide support at the State and community-level to prevent and reduce the use of alcohol, tobacco and other drugs among youth and young adults. BHDDH utilizes a life span framework-across the Institute of Medicine (IOM) care continuum focusing on priority populations and activities, including but not limited to substance abuse prevention, mental health promotion, violence prevention and tobacco control to promote health and mental wellness in Rhode Island (RI). The life span (course, or stages) framework helps to explain health and disease patterns, particularly health disparities, across populations and over time.

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

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

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

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

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

- Assess prevention needs based on epidemiological data

- Build prevention capacity
- Develop a strategic plan
- Implement effective community prevention programs, policies and practices, and
- Monitor, evaluate and document outcomes

Developing an integrated behavioral health infrastructure is an on-going process. It is important to note that 2016 begins a transitional period as the State rolls out a new prevention service delivery model. It is of paramount importance that the State, its providers, and stakeholders identify the necessary changes to work towards creating greater behavioral health equity in the State. The State aspires to provide equity by offering the highest level of behavioral health to all people and supporting concerted efforts for those who have experienced social and/or economic disadvantages. The details of the State's amended strategic plan are presented below.

SECTION 2- RHODE ISLAND PREVENTION INFRASTRUCTURE OVERVIEW

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

Rhode Island's Governor's Council on Behavioral Health - The Rhode Island Governor's Council on Behavioral Health is the mental health and substance abuse planning council. It reviews and evaluates mental health and substance abuse needs and problems in Rhode Island. It stimulates and monitors the development, coordination, and integration of statewide behavioral health services. The Council serves in an advisory capacity to the Governor.

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

Rhode Island 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.

Rhode Island State Epidemiology Outcomes Workgroup (SEOW) - The primary mission of the SEOW is to guide in institutionalized data-driven planning and decision making relevant to substance

use/abuse and mental illness across Rhode Island. As such, the SEOW operates within the outcomes-based prevention framework, aiming to integrate prevalence and incidence data with risk and protective factors data into its decision-making process and policy-making at the state and community level.

Rhode Island Student Assistance Services (RISAS) - RISAS has been providing school and community-based substance abuse prevention and early intervention services to Rhode Island schools and communities since 1987. RISAS is implementing Project SUCCESS, an evidence-based SAMHSA program, in over 40 Rhode Island middle and high schools.

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

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

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Over the next five years the RPTF will use funding will be assessing our community substance abuse prevention needs and resources, developing a capacity building plan to address any gaps in resources or community readiness and a local strategic plan, implementing evidence based and best practice interventions based on community needs, and evaluating the impact of our efforts.

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

SECTION 3 - STATE SUBSTANCE ABUSE PREVENTION PRIORITIES BASED UPON THE 2015 RHODE ISLAND STATE EPIDEMIOLOGICAL PROFILE

The most recent Rhode Island State Epidemiological Profile (State EPI Profile) was completed in 2015. The purpose of the profile is to inform and assist in data-driven state and community-level planning and decision making processes relevant to substance use and mental health issues across the State of Rhode Island. The profile provides a comprehensive set of key indicators – micro level to macro level – describing the magnitude and distribution of:

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

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

The Substance Use and Mental Health in Rhode Island (2015): A State Epidemiologic Profile (“2015 State Epi Profile”) identifies key behavioral health findings based on national and regional data sets. This strategic plan incorporates and adopts a sub-set of these priorities which are then integrated, as appropriate, within the formulation of goals, objectives and activities described in this plan. Several factors lead to the selection of actionable priorities.

- Not all priorities or recommendations from the 2015 State Epi Profile are changeable within the time frame addressed with this current prevention strategic plan
- Some priorities are not changeable with primary prevention strategies
- Evidence based or evidence informed interventions fundable with the primary prevention set aside of the Substance Abuse Block Grant may not exist to address the priority

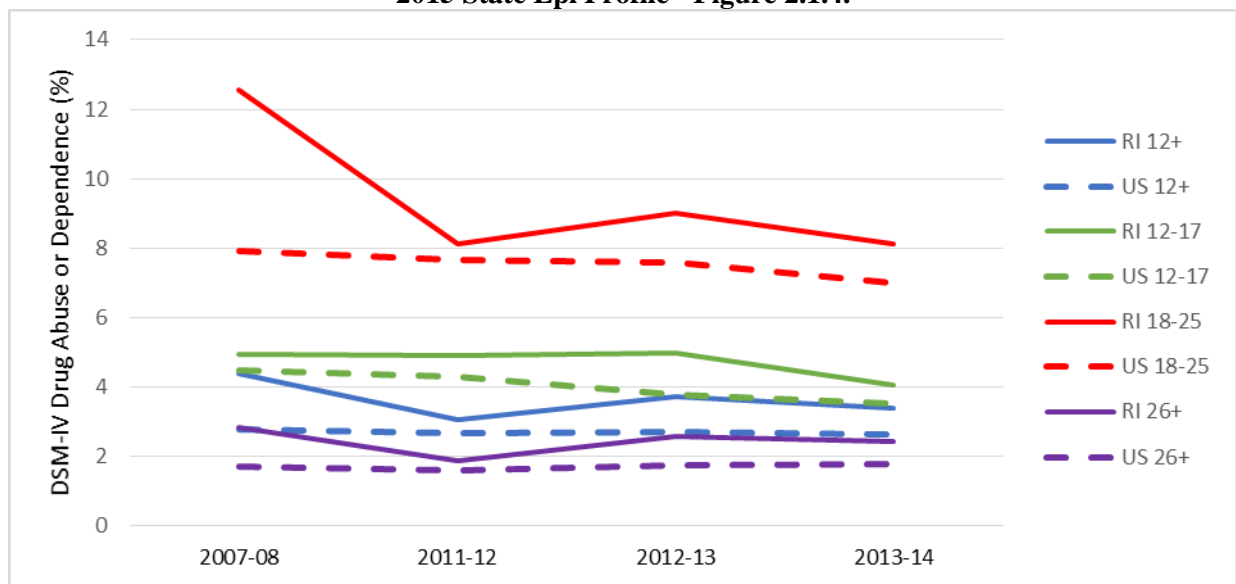
Please consult the full 2015 State Epidemiological Profile for additional analysis and information that provides the justification for the priorities noted in this plan. Time trend charts have been provided within body of this plan. The link to the Profile is available at www.riprc.org.

A. CONSEQUENCES OF SUBSTANCE USE - Priority Consequences for 2016-2019 Strategic Plan for Substance Abuse Prevention

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

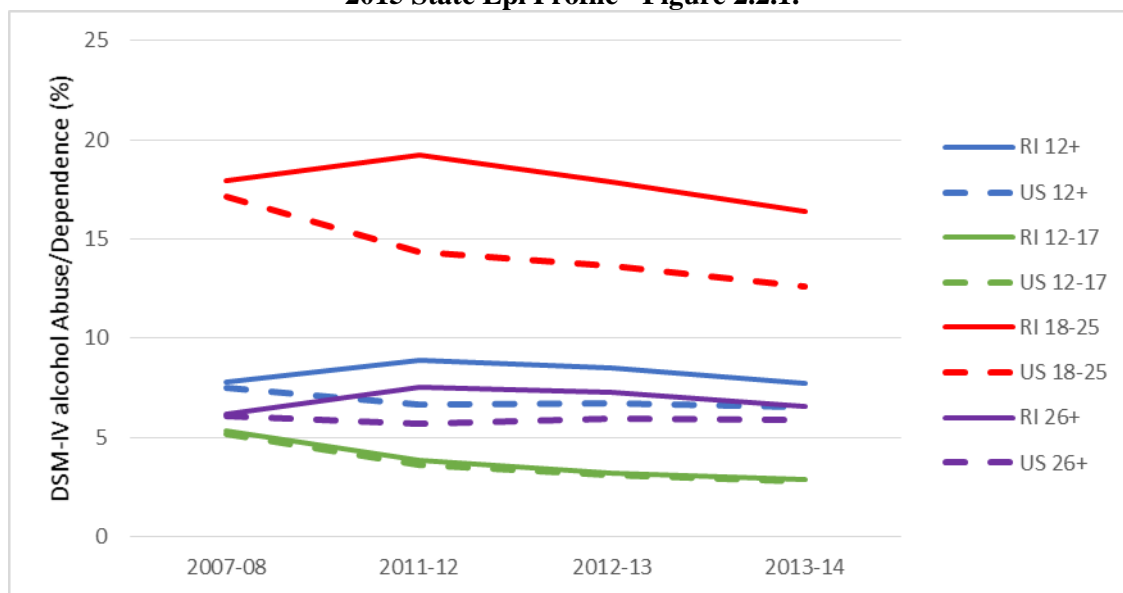
- A. DSM-IV diagnosis of illicit drug dependence or abuse
- B. DSM-IV diagnoses of alcohol dependence or abuse
- C. Drug overdose, especially those attributed to opioids and prescription drugs
- D. Suicide attempts among adolescents

RI vs. US DSM-IV Drug Abuse or Dependence by Age Group, 2007-2014
2015 State Epi Profile - Figure 2.1.4.



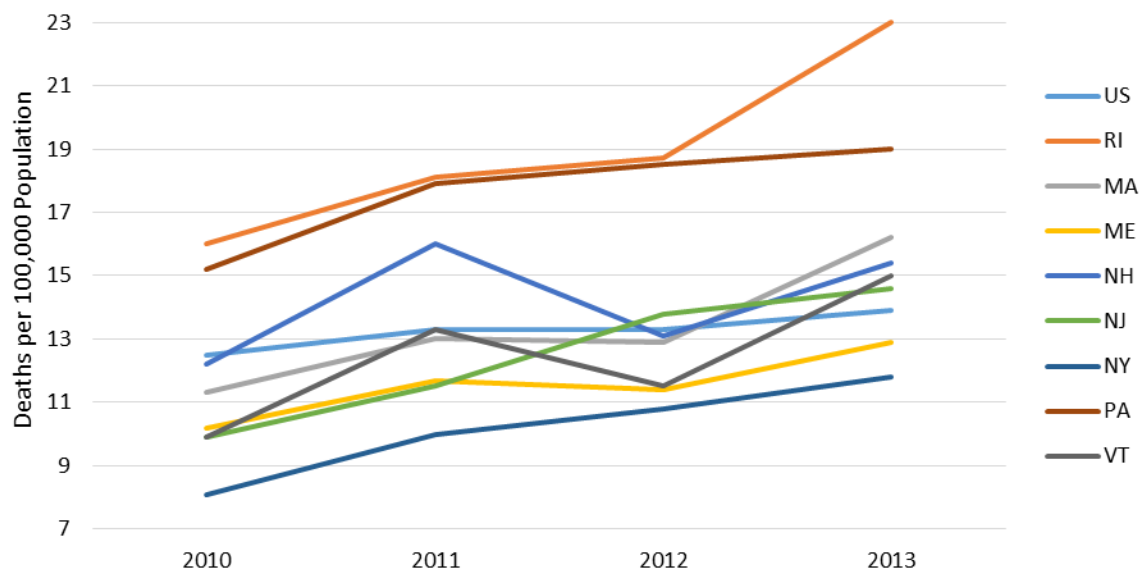
Source: National Survey on Drug Use and Health (NSDUH).

RI vs US DSM-IV Alcohol Abuse or Dependence by Age Group, 2007-2013
2015 State Epi Profile - Figure 2.2.1.



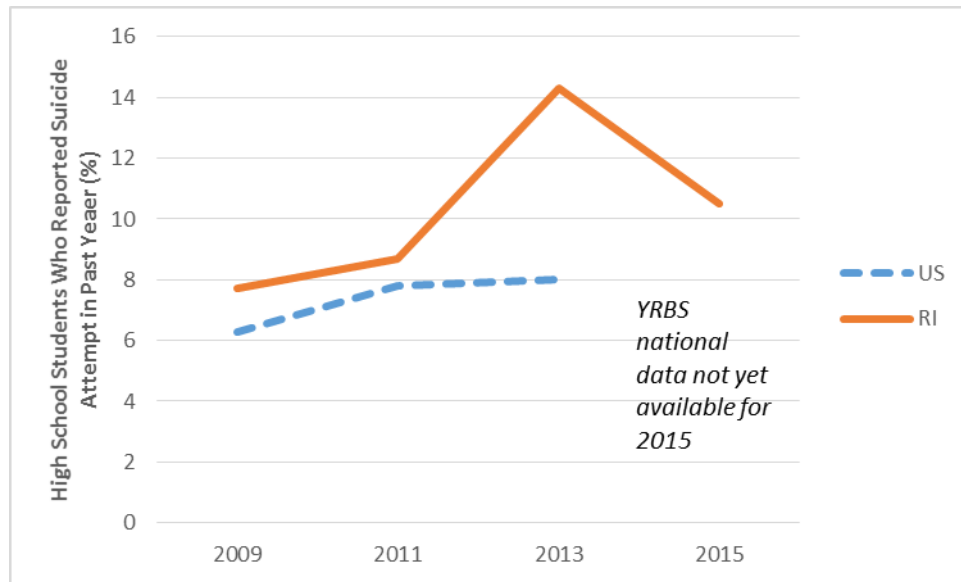
Source: National Survey on Drug Use and Health (NSDUH).

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.**

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-IV 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 elevated¹. 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.

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

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

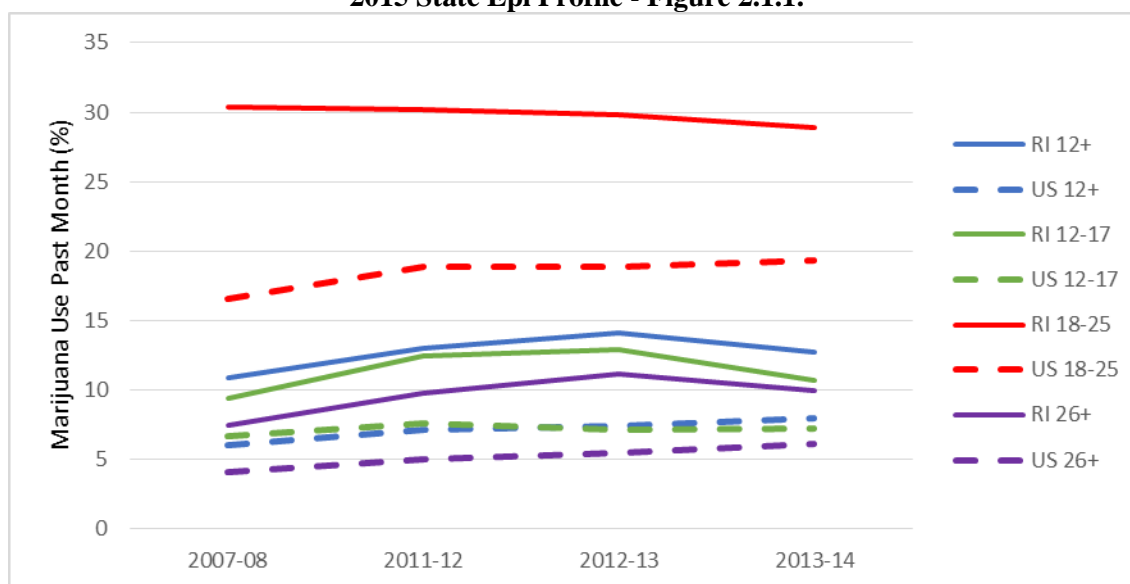
- A. Marijuana use by adolescents ages 12-17
- B. Use of illicit drugs other than marijuana 12-25
- C. Underage drinking 12-20
- D. Youth use of tobacco or tobacco related products especially use of electronic nicotine delivery systems (ENDS).

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.

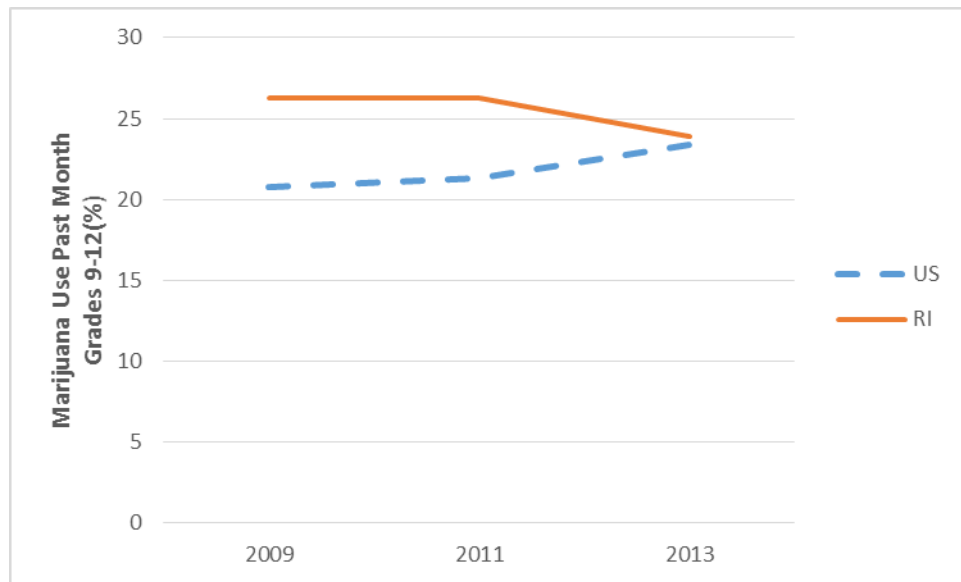
RI vs. US Marijuana Use Past Month by Age Group, 2007-2014
2015 State Epi Profile - Figure 2.1.1.



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 a 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



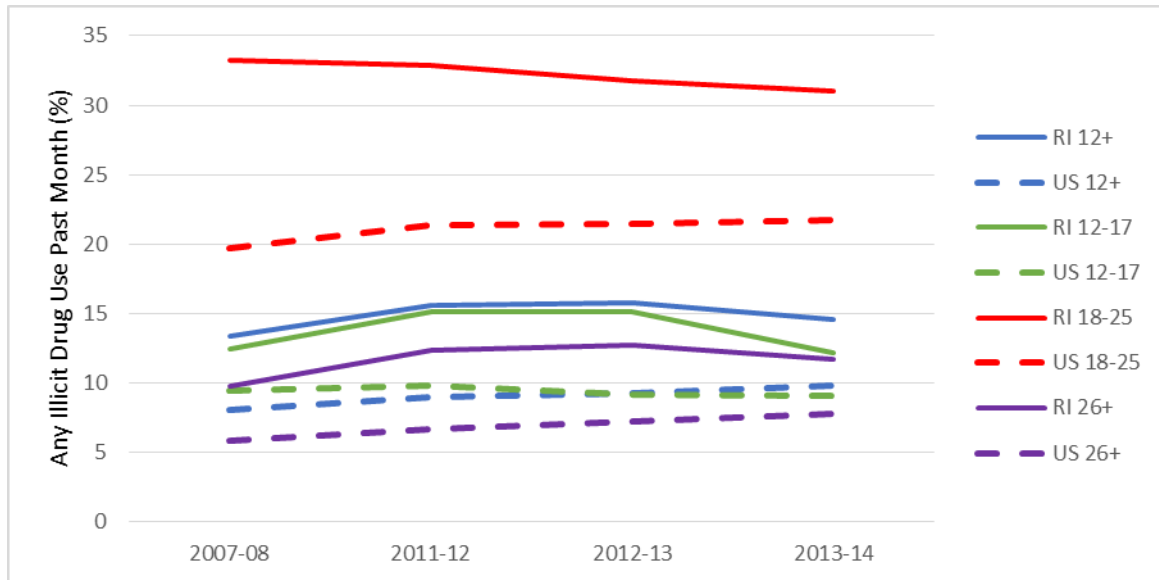
Source: Youth Risk Behavior Survey, Centers for Disease Control

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

With respect 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, resulting in an 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.

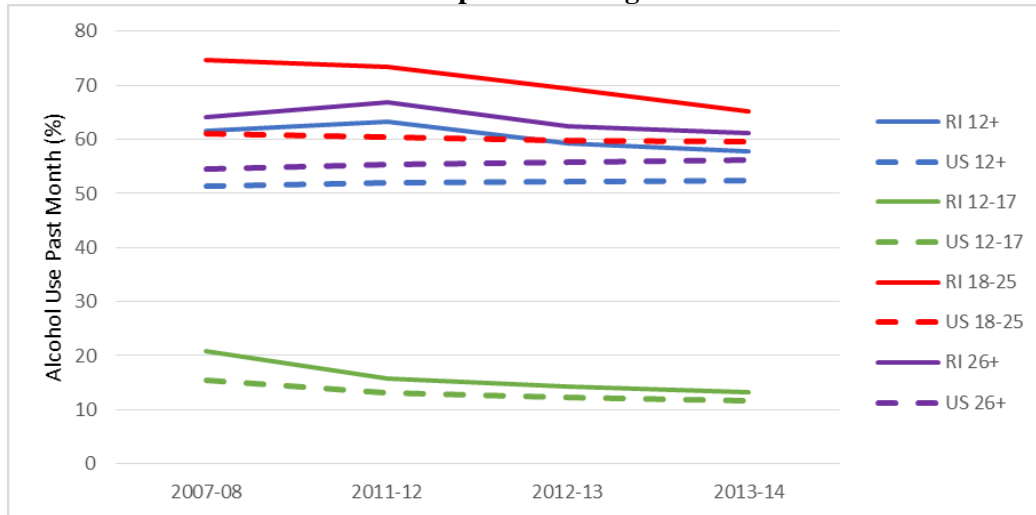


Source: National Survey on Drug Use and Health (NSDUH)

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.

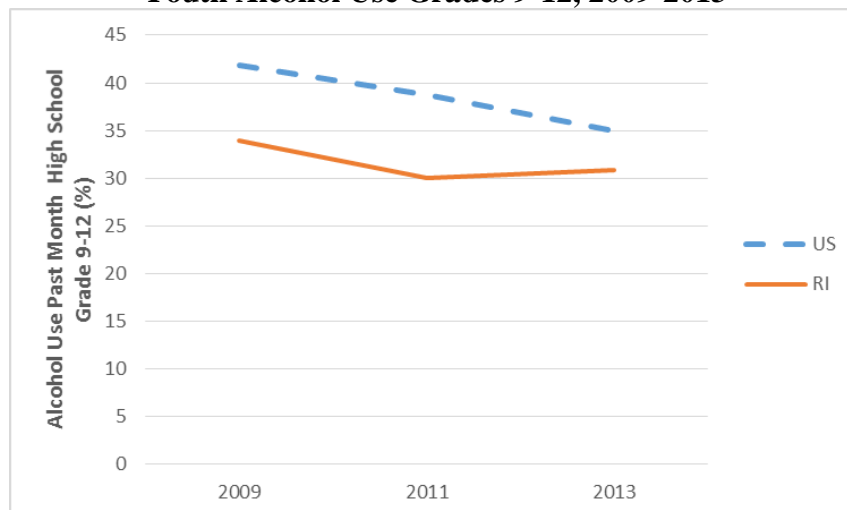
Alcohol Use Past Month by Age Group, 2007-2014
2015 State Epi Profile - Figure 2.2.0.



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.

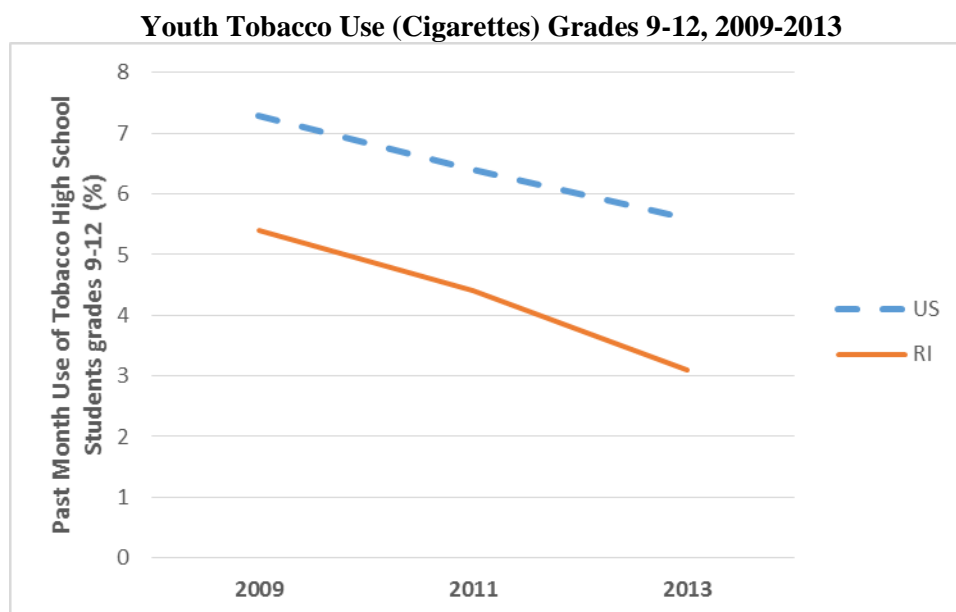
Youth Alcohol Use Grades 9-12, 2009-2013



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. 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.*



Source: Youth Risk Behavior Survey, Centers for Disease Control

C. RISK & PROTECTIVE FACTORS

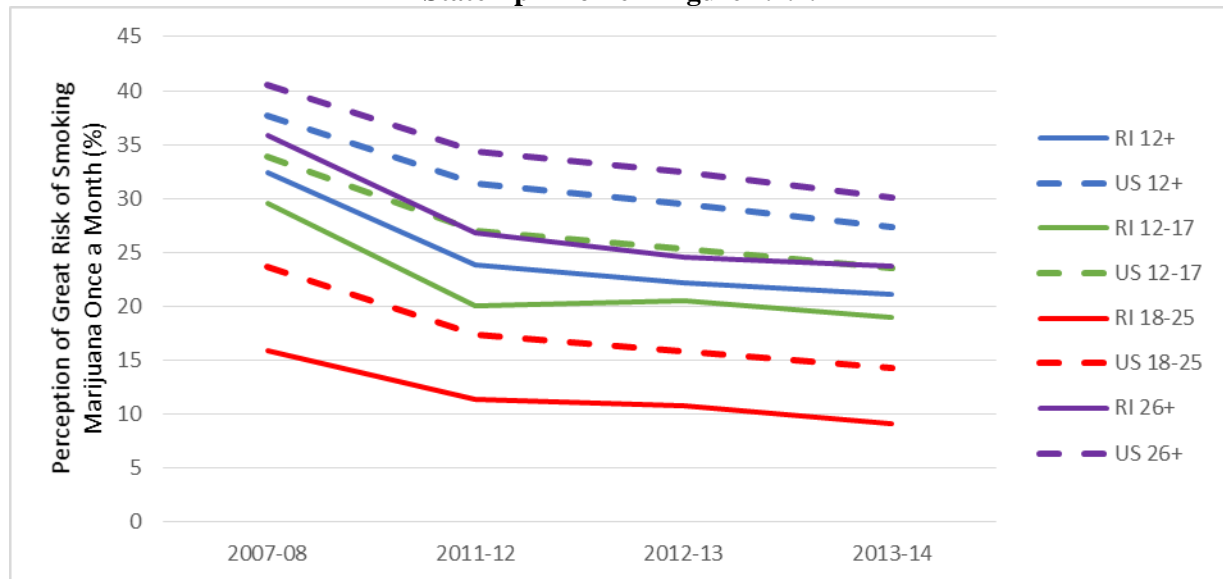
State or community level indicators related to behavioral health risk or protective factors are not as readily available as other indicators of consumption or consequences. The priority risk or protective factors are those that appear in research studies related to prevention of substance abuse. Currently, 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 time frame covered in this plan, either by existing pre or post-test surveys or the Rhode Island Student Survey.

1. 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).**

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)

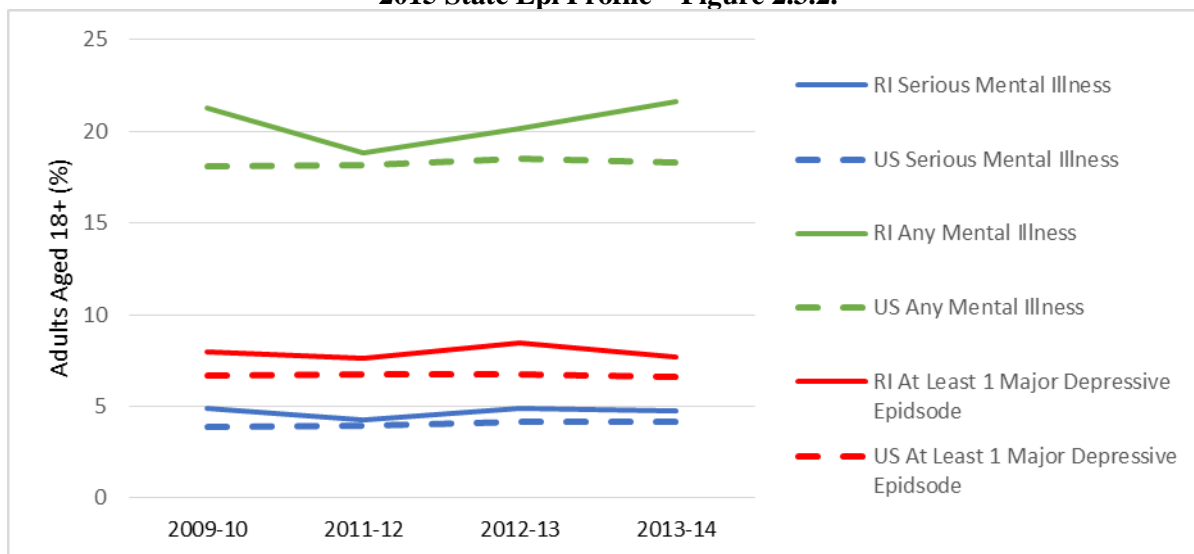
2. Access and Availability of Substances With Age Based or Other Conditional Use Restrictions

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.

D. MENTAL HEALTH

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)

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 2.3.3).

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.

SECTION 4 - ALIGNMENT WITH SAMSHA'S STRATEGIC INITIATIVES

The priorities identified through the 2015 State Epi Profile align well with SAMHSA's strategic initiatives, insuring that BHDDH and its' state and community partners are continually improving and refining capacity to address these issues across the state. In addition, focusing on workforce development, creating/sustaining state and community partnerships and improving/enhancing use of data guided decision making will poise RI well to leverage discretionary funding from SAMHSA to expand our reach.

SAMSHA's 2014-2018 prevention goals include:

Goal 1.1: Promote emotional health and wellness, prevent or delay the onset of and complications from substance abuse and mental illness, and identify and respond to emerging behavioral health issues.

Goal 1.2: Prevent and reduce underage drinking and young adult problem drinking.

Goal 1.3: Prevent and reduce attempted suicides and deaths by suicide among populations at high risk.

Goal 1.4: Prevent and reduce prescription drug and illicit opioid misuse and abuse

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

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

It is important to reiterate here that BHDDH's goal of developing an integrated behavioral health infrastructure is an on-going process with a major transitional period occurring in 2016 as it implements a new prevention service delivery model. BHDDH's priorities focus primarily on workforce development and infrastructure to support the behavioral health priorities of SAMHSA.

SECTION 5 - STRATEGIC PLANNING GOALS AND OBJECTIVES

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

A. SYSTEM-LEVEL INFRASTRUCTURE DEVELOPMENT:

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

Objective I: By January 31, 2017, BHDDH will implement a new prevention service delivery model.

Objective II: By April 1st Task 1 will be completed – Regional Prevention Coalition Formation, Organizational Development and Partnership Development Identify key staff for the regional coalition including the regional coordinator and fiduciary agent

Objective III: By July 1st Task 2 will be completed– Conduct Regional and Municipal Needs Assessments

Objective IV: By July 1st Task 3 will be completed- Create Regional Strategic Plans and Municipal Work Plans Addressing State Identified Priority Problems (Includes Capacity Building Plans)

Objective V: Ongoing after July 1st and through option years 2018-2021 if funding is available Task 4 – Implement, Monitor, Evaluate and Sustain Activities within Regional Prevention Strategic Plan and Municipal Work Plans

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

Objective I: By Dec 31, 2017 (and for each year after) BHDDH will document the surveillance of current providers for prevention and mental health promotion on the state and community level(s) to ensure contract deliverables are being met and document the integration of behavioral health across prevention initiatives through the production of an annual summary report presented to the PAC and to the Governor's Council on Behavioral Health. The summary report will document the integration of mental health promotion in substance use prevention initiatives across the following state and community level organizations:

- a) State-level:
 - 1. URI, Statewide Evaluation Contracts

2. State Epidemiology Outcomes Workgroup (SEOW)
3. RI Prevention Resource Center (RIPRC)
4. Evidence-based Workgroup
5. Overdose Prevention Workgroup
- b) RI Substance Abuse Prevention Act (RISAPA)/Regional Prevention Task Force Grantees
- c) Marijuana and Other Drug Initiative (MOD) Grantees
- d) Partnership for Success (PFS) Grantees
- e) RI Student Assistance Service (RISAS) Grantee

Objective II: Maintain a consistent meeting schedule of groups addressing behavioral health issues. Each meeting will specifically identify opportunities to address the following: 1) to increase communication across the sectors; 2) to identify increased opportunities for collaboration across sectors; 3) to ensure promotion of existing prevention services and initiatives and; 4) to document the integration of prevention and mental health promotion across behavioral health provider systems.

Meetings will include and meet as follows:

- a) Governor's Council on Behavioral Health: Monthly
- b) SEOW: Quarterly
- c) RI Prevention Certification Board: Quarterly
- d) RISAPA Grantees: Monthly (this may vary as this is a voluntary, provider-led group)
- e) RIPRC: Monthly
- f) MOD: Quarterly
- g) PAC: Bi-monthly
- h) PFS: Quarterly
- i) RISAS: Quarterly
- j) Evidence-based Practices Workgroup: At least quarterly
- k) Overdose Prevention Workgroup: Monthly

Objective III: By July 31, 2017, BHDDH will update, based on recommendations from the evidence-based workgroup, data-driven, promising and evidence-based practice standards for all funded prevention providers in order to meet the requirements outlined in the strategic plan.

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

Objective I: By July 31, 2017, the PAC will recruit and maintain 80% of required representatives appointed by the Governor's Council on Behavioral Health and maintain a minimum of 15 professionals representing a broad range of content expertise, including but not limited to required representatives (*refer to list below*).

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

- 1) BHDDH Prevention and Planning Unit*

- 2) Department of Health (HEALTH) and/or Community Violence Prevention and/or Suicide Prevention *
- 3) RI Substance Abuse Prevention Act (RISAPA) *
- 4) Mental Healthcare
- 6) Certified Prevention Specialist*
- 7) Student Assistance Program *
- 8) State Epi Outcomes Workgroup (SEOW) *
- 9) Department of Youth and Family Services Prevention Specialist/Family Community Care Partnership Representative (s)
- 10) Military Prevention
- 11) School-based Healthcare
- 12) Community/School Health Educator (s)
- 13) Physical Healthcare Provider (s)
- 14) Parent Organizations
- 15) Law Enforcement
- 16) Tobacco Control Prevention Specialist (s)
- 17) Recovery and Treatment
- 18) Developmental Disabilities
- 19) RI Department of Education
- 20) Youth Organizations
- 21) Mental Health Promotion
- 22) Evidence-based Practice Workgroup

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

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

Objective III: By December 31st, 2016 (and for each year after), the Prevention Advisory Committee will assist BHDDH and the Governor's Council on Behavioral Healthcare to document the deliverables outlined in the RI Strategic Plan for Substance Abuse Prevention in a written annual report.

Goal Four: *Develop and document a plan to improve state and local cross organizational collaboration among funded providers who implement prevention initiatives. The plan will be designed to document the improvement of local, regional and/or state infrastructures to provide effective and inclusive behavioral health services.*

Objective I: By July 31, 2017, develop and implement a state-wide inventory of behavioral health prevention services, regardless of funding source.

Objective II: By July 31, 2018, develop and implement a state-wide inventory of data collected which may inform prevention efforts, regardless of funding source.

Objective III: By July 31, 2019, develop and implement a central, state-wide data collection repository of prevention data.

B. WORKFORCE DEVELOPMENT AND SUSTAINABILITY:

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

Objective I: By January 1, 2017, establish a modified prevention service delivery system which includes a multi-tiered classification of prevention providers. The classification will be designed, in consultation with the RI Certification Board, to acknowledge and document the varying levels of content expertise within the prevention service delivery system.

Objective II: By July 31, 2017, develop and disseminate a workforce development plan, which documents the criterion for a multi-tiered classification of prevention providers* and a plan to provide on-going professional development opportunities to increase the capacity of funded prevention providers.

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

Objective I: By December 31, 2018 (and every year after), BHDDH will develop an annual report utilizing prevention data to analyze and report on process and outcome measures to determine the effectiveness of the state's prevention and mental health promotion system and to make recommendations for improvement.

Objective II: By December 31, 2019 (and every year after), BHDDH will develop and/or update a sustainability plan to specifically outline prevention and mental health promotion programming, policies and initiatives.

Objective III: By July 31, 2018, develop and disseminate a suite of training and performance monitoring tools to guide on-going prevention program improvement.

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

Objective I: By July 31st, 2019 increase the number of funded substance abuse prevention providers who are active (not expired or newly hired) who are credentialed at the level of Certified Prevention Specialist or above from 32% to 75%

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

Objective II: By July 31, 2016 (and for each year after), BHDDH will ensure the RI Prevention Resource Center and funded prevention providers will collect data, report data, and identify data-driven program planning in reporting accordingly:

RISAPA/Regional Prevention Task Force Grantees: Monthly Reporting
MOD Grantees: Quarterly Reporting
PFS Grantees: Monthly Reporting
RIPRC: Quarterly Reporting and Annual Report
RISAS Grantees: Monthly Reporting

Objective III: BHDDH, through a training and technical assistance contract, will provide a minimum of 10 on-line or face-to-face trainings and a minimum of 100 technical assistance (TA) contacts annually.

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

Objective IV: Between January 1 and June 30, 2017, funded prevention providers will assess local needs, resources and readiness and develop a plan to reduce the impact of at least one of the state identified priority areas (presented below and in Section 3 of this plan). Funded providers will utilize State and local data to inform these data-driven programmatic planning, implementation and evaluation activities.

Objective V. By July 31, 2019, 80% of funded substance use prevention providers will engage representatives from the following six sectors:

- Business
- Education
- Safety
- Medical/health
- Government
- Community/family supports

Objective VI: After January 1, 2017, funded providers will address a minimum of one of the following priorities based on the results of the municipality's needs assessment and regional strategic plan:

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

- Prevent and/or reduce consequences of underage drinking, ages 12-17 and adult problem drinking, ages 18-25.

- Prevent and/or reduce consequences of marijuana use by adolescents ages 12-17
- Prevent and/or reduce consequences of illicit drug use other than marijuana ages 12-25
- Prevent or reduce consequences of youth use of tobacco or tobacco related products especially use of electronic nicotine delivery systems (ENDS).

Goal Eight: Funded prevention providers will measure and document two outcomes associated with BHDDH's prioritized risk factors.

Objective I: Between January 1st, 2017 and December 31st, 2019, funded entities should increase the perception of risk of harm associated with the chosen priority substance by 10% among the target population.

Objective II. Between January 1st, 2017 and December 31st, 2019, funded entities should reduce the access or perceived ease of access among populations for whom possession, use or consumption is illegal by 10% among the target population.

SECTION 6 - SUMMARY and CONCLUSION

BHDDH will use the strategic planning goals and objectives from Section 6 (Strategic Planning Goals and Objectives) to address the priority problems identified in the 2015 State Epidemiological Profile. While the Department strives to reduce the number of individuals who meet diagnostic criteria for substance use disorders, it is unlikely that the current primary prevention resources will have sufficient reach or intensity to produce a measurable change during the time frame covered in this strategic plan. BHDDH will measure change in the positive direction with risk or protective factors targeted within communities or regions on magnitude of 10% over baseline along a similar three year cycle among those populations, again where there are available data to measure change at the community or regional level.

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

Prevention
Process and Outcome Evaluation of Services Plan
6/1/2017 – 5/31/2022

1. Regional Prevention Task Forces Evaluation

The CRST will design and conduct a multi-level, cross site evaluation that covers the following:

- a. Assessing the efficacy of this newly formed Regional Prevention Coalitions model as a viable delivery system for substance abuse prevention services and mental health promotion.*

The CRST will assess the efficacy of the newly formed Regional Prevention Coalition model as a viable delivery system for substance abuse prevention services and mental health promotion using several statistical methods and data sources. Elements of social network analysis will be utilized to evaluate the state of the current prevention infrastructure (year 1), and compare this with any changes that may occur at years 3 and 5 of the project. Social network analysis is a tool that is often used to represent the structure relationships between people, organizations, goals, interests, and other entities within a larger system (Hoppe & Reinelt, 2010), and can be used to assess connectivity across networks, overall network health, and network outcomes and impact.

The CRST will address each of these domains in the evaluation of the newly formed Regional Prevention Coalition model.

Connectivity. Connectivity refers to the number and structure of connections within the social network. An evaluation of connectivity within and across regions can be useful in determining whether the structure of the network enables efficient sharing of information, ideas, and resources. From this framework, the CRST will describe relationships among people and organizations within the regional and community network at baseline, in each year of the project, and at follow-up. The CRST will utilize this information to identify influential people and organizations within each region and across the state, as well as to identify potential areas of future growth and collaboration. Specifically, the number of ties across different sectors within each region will be calculated from survey data obtained from regional coalition leaders and members, as well as from data entered into the Mosaix IMPACT system. These data will be used to help answer the following questions: 1) is network membership across sectors growing and expanding over time; 2) is the proportion of members who are active in the network growing; and 3) are members both bonding and bridging in the network.

Network health. Network health refers to how well a network is functioning. Evaluation questions related to network health include: 1) are regional coalition leaders participating and exercising leadership as they are able to, and would like to; 2) what is the level of trust among members in the network; and 3) what are the power relationships within the network and how are decisions made. Data for these questions will be obtained from an annual coalition leader/member survey administered within each region by the CRST.

Network outcomes and impact. Evaluation questions related to network outcomes and impact can refer to change at the individual, organizational, and/or community level. These questions typically seek to answer the following: 1) is there evidence of greater coordination among leaders; and 2) does the network make use of existing resources to produce desired results, and/or how are resources allocated and leveraged within each region. Data for the former question will be obtained from the annual coalition leader/member survey administered within each region by the CRST. Data for the latter question will be obtained from regional financial records, as well as information entered into the Mosaix IMPACT system.

b. Fidelity to the model proposed in the Regional Prevention Task Forces RFP #7550738 by the Regional Prevention Coalitions, including reporting on process measures below for each region and municipality.

i. Expansion of Six Core Sectors (from IMPACT as described in Appendix I).

Data regarding expansion of the Six Core Sectors (business, education, safety, medical/health, government, community/family supports) will be obtained from the Mosaix IMPACT system for each region and municipality funded by the project. Engagement will be measured by counting the number and frequency of cross-sector activities entered into the system over time. Annual summary data for each sector across regions will be made available to the funder, as well as in the final evaluation report for the project. As indicated in the scope of work for the project, it is expected that sector representation is expected to increase at the municipal and regional levels in years 2-5 to include multiple stakeholders within each sector sub-population.

ii. Completion rates for biannual RISS administration (from RI Student Survey Dashboard as described in Appendix I).

Completion rates for biannual RISS data will be calculated by the CRST. Compliance with the following requirements will be assessed: 1) 2018- 80% of the districts within the Region must participate with a minimum of 2 grades; 2) 2020- 80% of the schools within each district in the Region must participate with a minimum of 2 grades; and 3) 2022- 80% of grades 7-10 in the municipalities within the Region will participate with a

minimum of 2 grades. The CRST will also assess whether or not each region has a plan for qualitative data collection for non-adolescent populations (Non-RISS data collection). These data will be made available to the funder in an outcome evaluation report for the RISS in each year of its administration, and in the final evaluation report.

c. Effectiveness of each Regional Prevention Coalition in achieving capacity/infrastructural outcomes sought described in the RFP (at pages 9 and 10) and below:

- i. 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 based on the findings of the municipal needs assessments.*
- ii. 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).*
- iii. 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.*

The CRST will assess effectiveness of each Regional Prevention Coalition in achieving capacity and infrastructure across domains i, ii, and iii by monitoring: 1) the number of evidence-based practices and programs implemented within each region and municipality at baseline and across funding years; 2) the number and type of implemented environmental change strategies aimed at raising awareness of potential for harm or youth access to harmful legal products; and 3) the number and type of communication strategies used to promote positive behavioral health, increase the perception of risk or harm from substance use, and correct normative misunderstandings of use among youth and young adults. Data for these evaluation questions will be derived from the Mosaix IMPACT system, as well as from the RISS, where applicable. Descriptive data regarding the number and type of programs implemented across the lifetime of the project for each region will be included in the final evaluation report.

d. Effectiveness of the specific evidence based practices (EBP) implemented and their impact on achieving behavioral outcomes sought described in the RFP (at page 12) and below:

- i. Increase in the percent of in-school, school-aged youth expressing disapproval of use alcohol, tobacco, and other drugs (ATOD) by 10%.*
- ii. Reduction in the percent of in-school, school-aged youth reporting current (past 30-day) use of ATOD by 3%.*

Data regarding youth disapproval of alcohol, tobacco, and other drug use will be assessed using information obtained from the RISS. Data regarding 30-day prevalence of ATOD use will also be obtained from the RISS, and will be presented to the funder after each administration of the RISS, as well as in the final evaluation report. Where available, fidelity measures will be administered to communities implementing evidence-based curricula in schools. These data will be used to assess degree of adherence to established curricula in an effort to increase the likelihood of obtaining desired behavioral outcomes for school-aged youth.

e. Effectiveness in accomplishing key sustainability tasks outlined in RFP #7550738 including funds diversification and broad based engagement of multiple stakeholders among the six core sectors who may be able to leverage or provide additional resources to support the goals and activities of the municipal prevention task forces as well as those throughout the region.

Effectiveness in accomplishing key sustainability tasks will be assessed as part of the network outcomes and impact social network evaluation described in Section 1a above. In addition to calculating the number of linkages across multiple stakeholders within the six core sectors identified in the RPF, the CRST will use data obtained from the Mosaix IMPACT system to determine whether there is an increase in funded stakeholder activities across the lifetime of the project.

f. Participation and attendance at meetings of the State Epidemiology and Outcomes Workgroup (so long as it continues to meet) and Prevention Advisory Committee.

The CRST has demonstrated a long-standing commitment to attending meetings of the State Epidemiology and Outcomes Workgroup and Prevention Advisory Committee, and will continue to do so throughout the lifetime of this project.

2. Rhode Island Student Assistance Services/Project Success Evaluation

The CRST will conduct a state-level process and outcome evaluation of the Rhode Island Student Assistance Services/Project Success program using data obtained from the RISS and the Mosaix IMPACT system.

Process evaluation. The process evaluation will measure fidelity to the Project Success model, with particular regard to the following elements which are implemented in school settings by Project Success/Student Assistance Counselors:

- i. Prevention Education Series (Four required topic areas)
- ii. Groups
- iii. Assessment and referrals

- iv. School wide activities
- v. Parent focused programs/activities

Fidelity measures will be administered to Student Assistance Counselors in each school implementing Project Success. These evaluations will target adherence to standard policies and practices required by Project Success for each of the domains listed above. Data will be aggregated at a municipal and regional level, and will be reported to the funder annually, when possible.

Outcome evaluation. The outcome evaluation will measure differences in prevalence rates and select risk and protective factors at baseline and after successful implementation of Project Success. Data regarding prevalence rates and risk and protective factors targeted by the intervention will be obtained from the RISS biannually. In addition, the CRST will compare prevalence rates and select risk and protective-factors across non-Project Success schools and Project Success Schools.

3. Rhode Island Prevention Resource Center Evaluation

The CRST will conduct state level process and outcome evaluation of the Rhode Island Prevention Resource Center (RIPRC) program using data obtained from the Mosaix IMPACT system.

Process evaluation. The process evaluation will measure RIPRC service satisfaction. CRST will perform an annual satisfaction survey monkey on those who have participated in training or received technical assistance from RIPRC. CRST will perform key informant interviews via phone with a percentage of the training and technical assistance recipients. A report will be provided with the results.

B. PERFORMANCE MEASURES

1. Timeliness of reports – Draft, final and annual evaluation plans are delivered on date due.

The CRST has a long history of providing timely draft, final, and annual evaluation reports on other projects completed for BHDDH. The CRST will continue to meet these demands within the scope of this work. In addition, the following considerations regarding data collection, management, analysis and reporting will be implemented by the CRST:

- **Data collection:** Data will be collected at regular intervals from the Mosaix IMPACT system, as well as from surveys administered by the CRST. The CRST will work to establish strong collaborative relationships with key stakeholders in order to obtain data

that can be aggregated at an appropriate level for statistical analysis. Where possible, the CRST will obtain data that provide key demographic and location information, as well as data that can demonstrate change over time on measurable outcomes specified by the project.

- **Data management:** Data will be collected, stored, and password-protected on two secure laptop computer at the CRST offices in Providence, RI. Data from the RISS will be de-identified prior to analysis, and results from analyses with small sample sizes will be suppressed to protect confidentiality. The lead evaluator will complete all data reports and manage all datasets associated with the evaluation. A graduate student researcher will be employed to assist with administrative duties related to data collection, data cleaning, and data management. Data will not be shared with unauthorized parties and confidentiality will be maintained throughout the duration of the project in accordance with standard data management practices.
- **Data analysis:** Members of the CRST hold multiple graduate level degrees in clinical psychology and statistics, and are well-versed in quantitative and qualitative data analysis methods. The CRST will adhere to strict standards for data analysis and reporting, and employ methods appropriate for the level of detail available in each dataset examined. The CRST are committed to producing high-quality evaluation products and educating consumers on the best methods for interpreting available data. Data will be reported with appropriate confidence intervals whenever direct comparisons are made between communities or groups to facilitate proper interpretation of key results. Process and outcome evaluations will be conducted, with specific emphasis on key objectives outlined in this proposal.
- **Reporting of data for the population(s) served:** Key stakeholders will receive annual reports demonstrating the impact of intervention efforts, as well as areas for possible improvement. The CRST will meet regularly with key stakeholders to discuss results from outcome and process evaluation efforts to maximize program effectiveness. Reports will be available as needed to communities to facilitate coordination and re-organization of ongoing prevention efforts, when necessary.

2. *Comprehensiveness/completeness of reports and presentations- all major constructs covered in the scope of work are contained in the reports and presentations.*

Overall, the CRST will design and implement a comprehensive evaluation of the organization, activities, outputs, and outcomes of the Regional Prevention Coalitions model, as well as for the Rhode Island Student Assistance Services/Project Success program. Emphasis on a comprehensive approach indicates that the evaluation will be:

- **Multi-level:** The evaluation will document and assess activities, outputs, and outcomes at the state level, as well as at the regional level.
- **Process-focused:** The evaluation will document organizational structures at the state and regional levels, decision-making procedures, extent of collaboration, outputs of program activities, and fidelity to more structured (curricular programs) and less structured (environmental change strategies) activities.
- **Outcome-driven:** The evaluation will measure the degree to which prevention efforts at the new regional and state levels influence ATOD use and perception of risk/harm among the population of interest. The CRST will also assess the degree to which the state achieves system change with respect to data systems, reporting by regions, and the nature and extent of support activities. The evaluation will be designed to determine which regions produce change, by how much, and how these changes influence state-level results.
- **Participatory/Collaborative:** The CRST evaluation team will work collaboratively with BHDDH, the RI SEOW, the Prevention Advisory Committee, the RIPRC, and all local community stakeholders to develop an inclusive, collaborative evaluation plan in which all key stakeholders have the opportunity to share their voice. Support to communities will be provided through timely and relevant feedback of evaluation data and findings, technical assistance, data resources, and training, where necessary.

3. *Responsiveness – how many adaptations are proposed and addressed at BHDDH’s request.*

The CRST has a demonstrated commitment to working collaboratively with BHDDH to meet specific evaluation needs, whenever possible. The CRST asserts that it will continue to work closely with BHDDH in order to further meet this need and facilitate communication between key stakeholders.

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Department licenses 7 community mental health organizations that, as described in detail in Step 1, provide the continuum of services from treatment and recovery services (including peers supports and supported employment) to housing (specialized group homes, supervised apartments, supportive housing). The service models include integrated health homes and ACT, intensive out-patients and out-patient.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

- | | |
|---|--|
| a) Physical Health | <input checked="" type="radio"/> Yes <input checked="" type="radio"/> No |
| b) Mental Health | <input checked="" type="radio"/> Yes <input checked="" type="radio"/> No |
| c) Rehabilitation services | <input checked="" type="radio"/> Yes <input checked="" type="radio"/> No |
| d) Employment services | <input checked="" type="radio"/> Yes <input checked="" type="radio"/> No |
| e) Housing services | <input checked="" type="radio"/> Yes <input checked="" type="radio"/> No |
| f) Educational Services | <input checked="" type="radio"/> Yes <input checked="" type="radio"/> No |
| g) Substance misuse prevention and SUD treatment services | <input checked="" type="radio"/> Yes <input checked="" type="radio"/> No |
| h) Medical and dental services | <input checked="" type="radio"/> Yes <input checked="" type="radio"/> No |
| i) Support services | <input checked="" type="radio"/> Yes <input checked="" type="radio"/> No |
| j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) | <input checked="" type="radio"/> Yes <input checked="" type="radio"/> No |
| k) Services for persons with co-occurring M/SUDs | <input checked="" type="radio"/> Yes <input checked="" type="radio"/> No |

Please describe as needed (for example, best practices, service needs, concerns, etc)

The Department is using evidence based practices including integrated health homes, supported employment, housing first, and centers of excellence for medication assisted treatment. The Department has developed a peer support certification program that allows for specializing in areas such as mental health, homelessness, HIV/AIDS, re-entry, and women who inject drugs. The program also has developed recovery centers throughout the state and a mobile outreach team to address "hot spots".

3. Describe your state's case management services
- BHDDH has implemented integrated health homes (IHH) which provides case management/care management. The Department also offers case management through supported employment and substance use treatment.
4. Describe activities intended to reduce hospitalizations and hospital stays.
- Through the integrated health homes, the Department, provides teams that offer community based services. The Department has created performance measures that include reduced admittance to the emergency department and necessary hospitalizations.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	4.5%	37000
2.Children with SED	17.3%	

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Rhode Island enjoys a robust and multi-layered approach to care management for children with serious emotional disturbances (SED) and adults with severe persistent mental illness (SPMI). Children with serious emotional disturbances are monitored by the state's Department of Children, Youth, and Families. As a subgroup of the Children with Special Healthcare Needs, Medicaid coverage is made available to make sure that all services are accessible.

The state's Integrated Health Home (IHH) and Assertive Community Treatment (ACT) programs are the primary sources of care for adults with severe persistent mental illnesses as well as a significant portion of the SMI population. IHH & ACT are integrated into Rhode Island Medicaid's Managed Care plans and, furthermore, Rhode Island is a Medicaid expansion state thereby rendering childless adults with incomes equal to or below 138% of the federal poverty line eligible for Medicaid coverage.

Sources:

SMI Adults, National Survey of Drug Use and Health (2014): This is an external data source. Rhode Island's Department of Behavioral Healthcare only tracks those individuals eligible for the IHH/ACT program which corresponds to both the SMI and the severe persistent mental illness (SPMI) population. It does not capture the entire SMI population.

SED Children, National Survey of Children's Health (2009/2010): This is an external data source. Rhode Island's Department of Behavioral Health does not collect these data; the state's Department of Children, Youth, and Families is responsible for tracking the SED Children population.

The only proxy for incidence would be to look at new people receiving treatment from our licensed providers and Medicaid that have not received it before. This would not be all inclusive as there are always individuals who develop mental health conditions who do not seek treatment from our licensed providers or Medicaid. They either do not seek treatment at all or they seek it from private physicians or other commercial or alternative providers.

The source of the statewide incidence is the 2014-2015 NSDUH.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

- | | | |
|----|--|---|
| a) | Social Services | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| b) | Educational services, including services provided under IDE | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| c) | Juvenile justice services | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| d) | Substance misuse preventiion and SUD treatment services | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| e) | Health and mental health services | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| f) | Establishes defined geographic area for the provision of services of such system | <input type="radio"/> Yes <input checked="" type="radio"/> No |

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

"Opening Doors RI" is Rhode Island's strategic plan to prevent and end homelessness. Adopted in 2012, the implementation plan was updated in 2016. The plan is consistent with federal priorities to decrease the number of individuals experiencing homelessness and to decrease the length of time individuals remain homeless. RI's plan prioritizes preventing and ending homelessness among veterans and to end chronic homelessness. Key initiatives target individuals experiencing chronic homelessness, veterans, families and youth.

RI has made considerable progress in meeting the established goal of ending functional homelessness among RI veterans. In 2016, 240 veterans experiencing homelessness were housed. The most recent Veterans Placement Committee report indicates that RI currently has 92 known veterans experiencing homelessness – 37 in shelters or living in places not suitable for human habitation and 55 in the grant-per-diem program of the VA which supports temporary housing for veterans. Currently, all persons are asked about military service in the initial assessment and that information is entered into HMIS. Efforts are being made to coordinate intake with the VA to ensure that chronically homeless veterans are able to access HUD-VASH. A recently-retired VA employee is represented on the CoC board and a psychologist from the VA participates in the monthly PATH implementation coordination meetings convened by one of the two PATH service providers. On a regular basis, trained peers from the local VA Medical Center accompany PATH outreach workers conducting street outreach. In addition, to implement the Opening Doors RI strategy to improve VA utilization of HMIS, the HMIS steering committee has and will continue to work with the VA to ensure that the grant per diem program, VASH projects and SSVF program are entering data into the HMIS.

BHDDH also administers the PATH program to provide statewide outreach and connection to mainstream services. The Homeless Management Information System does not provide a report that identifies individuals with severe mental illness by geographic area. The outreach team uses a mobile application, Fulcrum, to geographically track its outreach contacts. The breakdown of those contacts between July 2016 and June 2017 are as follows:

Providence: 3449
East Providence: 159
Pawtucket and Central Falls: 126
Kent County: 46
Washington County: 12

RI has one large metropolitan area centered around the capitol city, Providence, and several other smaller metropolitan areas. These municipalities comprise what has been designated as urban core and urban ring communities. These municipalities include: Central Falls, Cranston, East Providence, Newport, North Providence, Pawtucket, Providence, Warwick, West Warwick and Woonsocket. In addition, there are semi-rural areas in Washington County and western RI. The Town of Westerly is the largest municipality in the southern part of the State.

Currently, PATH outreach case managers are focused geographically in Providence, East Providence, Pawtucket, and Kent County (Coventry, East Greenwich, Warwick, West Greenwich and West Warwick). Because the preponderance of services are located in the Providence metropolitan area, many individuals who become homeless in areas outside of the city ultimately move there. Outreach workers also actively engage with individuals staying in tent encampments and uninhabitable buildings in outlying areas, including West Warwick and Foster which is located in the western part of RI.

RI also has established a Veterans Court to divert veterans from the criminal justice system and homelessness. This program remains in place despite a major reduction in available funding. The PATH program can both make referrals to this program and assume some case management responsibility once the individual has either completed treatment and/or has been released from court oversight.

Consistent with the COC's Zero 2016 initiative, the VI is administered to as many chronically homeless individuals as possible, both through PATH-supported outreach and outreach conducted through other funded and volunteer programs. Housing priority is determined by risk level. Individuals experiencing chronic homelessness and SMI most often have the highest vulnerability index scores; and, as such, are high on the coordinated housing priority list. Discrepancies between vulnerability index scores and assessed level of risk are resolved through a case-conferencing process. Case conferencing is coordinated by the PATH-funded RI Coalition for the Homeless.

PATH funds support the identification and screening of chronically homeless individuals through coordination of outreach efforts statewide, training of individuals in conducting street outreach, and managing the State's HMIS (RI Coalition for the Homeless)

and in an increase in PATH outreach workers, including trained peers (House of Hope). All outreach staff administer the VI-SPDAT as soon as possible after initial contact. Intake and assessment information is collected utilizing the FULCRUM data collection application. This information is then entered into HMIS. Efforts currently are underway to allow direct data entry from FULCRUM into HMIS.

BHDDH recently contracted to utilize the same on-line system as the HMIS. This system operates like an electronic health record and has the capability to be expanded to meet other departmental needs such as hosting an incident and complaint reporting system. Initially, only administrative-level data can be shared with other non-departmental entities; however, the intent is to expand data sharing through data use agreements and contractual relationships to enhance collaborative efforts to serve individuals with behavioral health conditions who are experiencing homelessness or are at risk of homelessness.

The strategic plan's goal to increase economic security for those who are homeless or at risk of homelessness includes a strategy to increase and improve access to mainstream benefits. Through this initiative, SOAR will be expanded to include a prison-based initiative; serving individuals experiencing chronic homelessness through increased collaboration with community mental health centers, community health centers, and hospital emergency departments; identifying high users of services and connecting at least 50% with benefits through SOAR. House of Hope is meeting with community mental health centers to facilitate referrals for PATH enrollees and to coordinate case management. House of Hope staff have received SOAR training, and the new state SOAR coordinator is a former employee of the agency. This individual participates in monthly PATH implementation meetings.

The two agencies currently receiving PATH funding also design, implement and participate in trainings intended to meet the strategic plan's strategy to provide comprehensive training to "front line" services staff and to cross train other workers assisting individuals experiencing homelessness. For example, PATH staff have participated in a statewide Housing First conference and will participate in a statewide SBIRT training in September, 2017.

Another objective outlined in the strategic plan is to expand access to primary care and appropriate care for chronic conditions. The plan calls for reestablishing the mobile van which previously served individuals experiencing homelessness and connecting them with FQHC's and supportive housing to increase access to primary care and integrated behavioral health care. There are several PATH-related initiatives, both current and soon-to-be implemented, designed to achieve this objective. In addition to on-going meetings with community FQHC's, House of Hope also is collaborating with several academic institutions located in RI. Currently, there are 67 students from three colleges/universities, including medical students from Brown University, who act as patient navigators. These students participate on outreach teams and work with clients who have complex health care needs (most frequently mental illness and co-occurring mental illness/substance use disorders) over an extended period of time to assist these individuals in obtaining needed health care services. Psychiatric residents from Brown University's School of Medicine, under the supervision of the PATH psychiatrist, also assist in psychiatric assessment and referrals. House of Hope also has secured philanthropic support for a mobile service van which will include a health exam room, an area for assessment/intake, and a computer area where individuals can apply for benefits. This van will be located on a rotating basis in areas where there are high numbers of individuals experiencing homelessness. Service is expected to begin in late 2017.

BHDDH, in conjunction with the Medicaid Division of the Executive Office of Health and Human Services also is working to establish an Integrated Health Home for individuals experiencing homelessness who also have multiple chronic conditions, including SMI.

Finally, PATH outreach services have been identified in the strategic plan to end homelessness as a critical component in the State's goal to end chronic homelessness in RI in five years, both through identification and coordination of evidence-based outreach practices, and expanding outreach efforts targeting chronically homeless individuals with SMI and SMI/SUD.

The Department participates in a monthly workgroup devoted to addressing the behavioral health needs of older adults in Rhode Island and is working closely with RI College to document unmet needs and create a plan to address these needs.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

The Departmental funds a percentage of fiscal, planning and the data and monitoring unit to the block grants. Since all members of these three units are involved in the implementation of the plan. The Planning Unit, includes an associate director and two administrators that are responsible for the sustainability and high level policy implementation and a block grant planner. The Data unit is comprised of one associate director, one administrator and a chief data staff. The data unit assists the in the identification and analysis of data from our State's MMIS and RIBOLD databases. The Fiscal and Contract monitoring unit, consists of one administrator, an accountant, 2 staff who are responsible for all budget reports, invoices and contracts and in contract monitoring one administrator and 4 contract monitors.

BHDDH contracts with the Substance Use and Mental Health Leadership Council to provide training and technical assistance to the providers on evidence based practices, best practices and services that promote the goals and strategies of the state's plan.

Footnotes:

Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i) Screening ☐ Yes ☒ No

ii) Education ☐ Yes ☒ No

iii) Brief Intervention ☐ Yes ☒ No

iv) Assessment ☐ Yes ☒ No

v) Detox (inpatient/social) ☐ Yes ☒ No

vi) Outpatient ☐ Yes ☒ No

vii) Intensive Outpatient ☐ Yes ☒ No

viii) Inpatient/Residential ☐ Yes ☒ No

ix) Aftercare; Recovery support ☐ Yes ☒ No

b) Are you considering any of the following:

Targeted services for veterans ☐ Yes ☒ No

Expansion of services for:

(1) Adolescents ☐ Yes ☒ No

(2) Other Adults ☐ Yes ☒ No

(3) Medication-Assisted Treatment (MAT) ☐ Yes ☒ No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? ☒ Yes ☒ No
2. Either directly or through an arrangement with public or private non-profit entities make perinatal care available to PWWDC receiving services? ☒ Yes ☒ No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? ☒ Yes ☒ No
4. Does your state have an arrangement for ensuring the provision of required supportive services? ☒ Yes ☒ No
5. Are you considering any of the following:
 - a) Open assessment and intake scheduling ☒ Yes ☒ No
 - b) Establishment of an electronic system to identify available treatment slots ☒ Yes ☒ No
 - c) Expanded community network for supportive services and healthcare ☒ Yes ☒ No
 - d) Inclusion of recovery support services ☒ Yes ☒ No
 - e) Health navigators to assist clients with community linkages ☒ Yes ☒ No
 - f) Expanded capability for family services, relationship restoration, custody issue ☒ Yes ☒ No
 - g) Providing employment assistance ☒ Yes ☒ No
 - h) Providing transportation to and from services ☒ Yes ☒ No
 - i) Educational assistance ☒ Yes ☒ No
6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Department's Contract Monitoring unit uses an audit tool created specifically to address the Block Grant requirements. The Quality Assurance Unit, which is part of the Executive branch of the Department takes complaints, grievances and does investigations and creates plans of actions with the Licensing unit. These plans are specific and have timelines which are followed up upon and the appropriate action is taken to ensure the Department is satisfied with the outcome.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	j n Yes j n No
b)	14-120 day performance requirement with provision of interim services	j n Yes j n No
c)	Outreach activities	j n Yes j n No
d)	Syringe services programs	j n Yes j n No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	j n Yes j n No
2. Are you considering any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	j n Yes j n No
b)	Automatic reminder system associated with 14-120 day performance requirement	j n Yes j n No
c)	Use of peer recovery supports to maintain contact and support	j n Yes j n No
d)	Service expansion to specific populations (military families, veterans, adolescents, older adults)	j n Yes j n No
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.
 The Department's Contract Monitoring unit uses an audit tool created specifically to address the Block Grant requirements. The Quality Assurance Unit, which is part of the Executive branch of the Department takes complaints, grievances and does investigations and creates plans of actions with the Licensing unit. These plans are specific and have timelines which are followed up upon and the appropriate action is taken to ensure the Department is satisfied with the outcome.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?

		j n Yes j n No
--	--	----------------
2. Are you considering any of the following:

a)	Business agreement/MOU with primary healthcare providers	j n Yes j n No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	j n Yes j n No
c)	Established co-located SUD professionals within FQHCs	j n Yes j n No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.
 BHDDH requires through regulations and contracts that all providers test for TB and refer individuals for treatment when appropriate. The contract monitoring unit at BHDDH ensures compliance. BHDDH planning and data units also review the Medicaid claims data for SUD and TB and when appropriate works closely with the DOH to address any discrepancies.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery?

		j n Yes j n No
--	--	----------------
2. Are you considering any of the following:

a)	Establishment of EIS-HIV service hubs in rural areas	j n Yes j n No
b)	Establishment or expansion of tele-health and social media support services	j n Yes j n No
c)	Business agreement/MOU with established community agencies/organizations serving persons	j n Yes j n No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.C.A§ 300x-31(a)(1)F)? ☒ Yes ☐ No
2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ☒ Yes ☐ No
3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ☒ Yes ☐ No

If yes, please provide a brief description of the elements and the arrangement

The Department is collaborating with the Ryan White Program administered by the Executive Office of Health and Human Services. BHDDH received a grant to ensure education, testing and treatment to individuals diagnosed with HIV or unaware. The problem is includes funding for education, testing, access to an infectious disease physician for OTP-health Homes and the inclusion of HIV education and training of all staff in Recovery Centers. The grant started in May 2017.

Criterion 8,9&10

Syringe System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement ☒ Yes ☒ No
2. Are you considering any of the following:
 - a) Workforce development efforts to expand service access ☒ Yes ☒ No
 - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services ☒ Yes ☒ No
 - c) Establish a peer recovery support network to assist in filling the gaps ☒ Yes ☒ No
 - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities) ☒ Yes ☒ No
 - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations ☒ Yes ☒ No
 - f) Explore expansion of service for:
 - i) MAT ☒ Yes ☒ No
 - ii) Tele-Health ☒ Yes ☒ No
 - iii) Social Media Outreach ☒ Yes ☒ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? ☒ Yes ☒ No
2. Are you considering any of the following:
 - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services ☒ Yes ☒ No
 - b) Establish a program to provide trauma-informed care ☒ Yes ☒ No
 - c) Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education ☒ Yes ☒ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449) ☒ Yes ☒ No
2. Are you considering any of the following:
 - a) Notice to Program Beneficiaries ☒ Yes ☒ No
 - b) Develop an organized referral system to identify alternative providers ☒ Yes ☒ No
 - a) Develop a system to maintain a list of referrals made by religious organizations ☒ Yes ☒ No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? ☒ Yes ☒ No
2. Are you considering any of the following:
 - a) Review and update of screening and assessment instruments ☒ Yes ☒ No
 - b) Review of current levels of care to determine changes or additions ☒ Yes ☒ No

- c) Identify workforce needs to expand service capabilities j ☒ Yes j ☒ No
- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background j ☒ Yes j ☒ No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? j ☒ Yes j ☒ No
2. Are you considering any of the following:
- a) Training staff and community partners on confidentiality requirements j ☒ Yes j ☒ No
- b) Training on responding to requests asking for acknowledgement of the presence of clients j ☒ Yes j ☒ No
- c) Updating written procedures which regulate and control access to records j ☒ Yes j ☒ No
- d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure j ☒ Yes j ☒ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? j ☒ Yes j ☒ No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

The Peer Review Team does 5% of all agencies receiving block grants funding; including OTP, residential and out-patient.

3. Are you considering any of the following:
- a) Development of a quality improvement plan j ☒ Yes j ☒ No
- b) Establishment of policies and procedures related to independent peer review j ☒ Yes j ☒ No
- c) Develop long-term planning for service revision and expansion to meet the needs of specific populations j ☒ Yes j ☒ No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? j ☒ Yes j ☒ No

If YES, please identify the accreditation organization(s)

- i) ☒ Commission on the Accreditation of Rehabilitation Facilities
- ii) ☐ The Joint Commission
- iii) ☐ Other (please specify)

The agencies are CARF accredited

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? j n Yes j n No
2. Are you considering any of the following:
 - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service j n Yes j n No
 - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing j n Yes j n No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
 - a) Recent trends in substance use disorders in the state j n Yes j n No
 - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services j n Yes j n No
 - c) Performance-based accountability j n Yes j n No
 - d) Data collection and reporting requirements j n Yes j n No
2. Are you considering any of the following:
 - a) A comprehensive review of the current training schedule and identification of additional training needs j n Yes j n No
 - b) Addition of training sessions designed to increase employee understanding of recovery support services j n Yes j n No
 - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services j n Yes j n No
 - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort j n Yes j n No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. § 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
 - a) Allocations regarding women j n Yes j n No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
 - a) Tuberculosis j n Yes j n No
 - b) Early Intervention Services Regarding HIV j n Yes j n No
3. Additional Agreements
 - a) Improvement of Process for Appropriate Referrals for Treatment j n Yes j n No
 - b) Professional Development j n Yes j n No
 - c) Coordination of Various Activities and Services j n Yes j n No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

http://www.bhddh.ri.gov/sections/rules_regulations.php

All Rhode Island State agencies are in the process of revising regulations per legislation. BHDDH is in the process of meeting with the community stakeholders to review our regulations and determine what needs the force of law, what can be certification standards or policies and procedures. This process must be complete by August 2018.

Footnotes:

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017?

☒ Yes ☐ No

Does the state have any activities related to this section that you would like to highlight?

Quality Improvement Plan - This plan will measure the service gaps and track programmatic improvements. Our reporting system tracks incidents that are categorized by the Department on an annual basis. Tracking these incidents allows the Department to track and trend areas of improvement and work with our stakeholders and community partners to develop innovative changes to improve the quality of care.

BHDDH Quality Assurance / Quality Improvement has protocols for tracking and trending to measure quality care. All licensed provider agencies and hospitals report incidents based on the Departments reportable incident criteria. All licensed provider agencies also report abuse, neglect, mistreatment, and exploitation of adults who have a Developmentally Disability as well as those adults who are disabled receiving care and treatment for behavioral health and substance use issues.

Quality Assurance / Quality Improvement Unit oversees all the incidents coming into the Department. This unit is responsible for daily monitoring of all critical incidents and emergencies. The Quality Assurance / Quality Improvement Unit triages all the calls and incidents in a Monday thru Friday daily triage meeting. Through the triage process the unit determines what rises to the level of abuse, neglect, mistreatment, and financial exploitation and then assigns those cases to investigative staff. The cases that do not rise to that level but require follow up are directed to the most appropriate place within the Department. For example, if there was a case that came in and our Behavioral Health Providers needed Technical Assistance then it would be referred to the Program Implementation Community Engagement Unit.

To ensure that all licensed providers are providing the quality of care and services as envisioned by the Department there is a comprehensive reporting and auditing process that all licensed providers are to adhere to. All providers have been trained in reporting incidents. In addition, the Licensing Unit within BHDDH also conducts biannual audits of comprehensive licensing regulations of these providers. Finally, comprehensive oversight is done by a team approach and / or clinical review that occurs when an incident comes into the Quality Improvement Unit and its investigative process determines a provider is in violation of the RI statutes, BHDDH regulations, or may be providing poor quality of care. Members from Quality improvement, Program Implementation, Licensing, and Data evaluation meet to discuss outcomes, improvements and any non-compliance concerns that to consistent with the scope of service being provided.

Noncompliance is noted in response to an audit or an investigation. Noncompliance is addressed by a plan of correction submitted to the Quality Improvement or to the Licensing Unit at BHDDH. Should provider agencies need technical assistance, BHDDH's Program Implementation and Community Engagement team would provide onsite training to help assist agencies in providing a more comprehensive quality of care service. In addition, The Department also meets regularly with the community and stakeholders such as; The Substance Use and Mental Health Leadership Council of RI; the New England Institute of Addiction Studies and The Community Provider Network of Rhode Island to discuss best practices to improve quality services and reduce non-compliance with regulations and state statutes.

The BHDDH legal Department also provides trainings on the Mental Health Law to work with our hospital partners to assure compliance with the Mental Health Law.

In April of 2017 BHDDH began to take a systematic approach to transitional youth to meet the Federal Guidelines on transitional youth. A team of individuals from our behavioral health unit and our Developmental Disabilities unit began meeting monthly with our DCYF state partners. During those meetings, a systematic approach was developed on referral process and tracking to effectively coordinate transition youth to adult services. The behavioral health unit and developmental disabilities unit provided cross training to DCYF and to the RI Family Court system thus creating a proactive team approach.

Finally, in August 2017 BHDDH will be implementing a new database; Therap. Therap will allow the Quality Assurance/Quality Improvement department to effectively do the following:

- Manage emergencies and critical incidents more efficiently by identifying levels I, II, III of incidents.
- Track caseloads of investigations in order to distribute and assign work more evenly amongst staff
- All reports and notifications to stakeholders and other partners will occur electronically. Therap
- Allow the Department to collect data on incidents by levels.
- Provided the Department with data tracking of incidents that are determined to be conclusive
- Tracking trends for specific providers and clients.

DCYF

DCYF has a comprehensive data and evaluation framework inclusive of a quality assurance system. DCYF currently utilizes the Rhode Island Child Information System (RICHIST) and the RIFIS system for data to serve as the basis for Continuous Improvement endeavors. The RICHIST system generates approximately 600 automated reports for monitoring and continuous quality improvement. This information has been critical in helping DCYF measure whether interventions put in place are having their intended effect and share their success with staff. The information is used to create a strategic dashboard for the DCYF director and senior management; this information is reviewed on a monthly basis with the leadership of the Department. RIFIS data has been used as part of an Active Contract Management process to continuously measure the effectiveness of the FCCP program and whether the services provided are achieving the outcomes of providing community services with wraparound approach to families with children with SED and at risk of higher level of involvement with out of home services or DCYF.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

[Trauma](#)⁶⁰ is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁶¹ paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? ☐ Yes ☐ No
2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? ☐ Yes ☐ No
3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? ☐ Yes ☐ No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ☐ Yes ☐ No

5. Does the state have any activities related to this section that you would like to highlight.

BHDDH is providing forums and training to behavioral health organizations through its training and technical assistance contract. The Department is training its training its staff and working with our community organizations, such as, Day One, that specialize in trauma informed care.

DCYF is providing monthly trainings on how to use the evidence-based functional assessment CANS (Child Adolescent Strength Needs) tool. This training includes training on the Trauma Modular. Information from the assessment is used for treatment planning and DCYF uses the data and analysis of the data for planning purposes.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁶²

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.⁶³

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

⁶² Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

⁶³ <http://csqjusticecenter.org/mental-health/>

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? ☒ Yes ☐ No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ☒ Yes ☐ No
3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? ☒ Yes ☐ No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? ☒ Yes ☐ No
5. Does the state have any activities related to this section that you would like to highlight?

The RIDOC is providing Medication Assisted Treatment in the prison through induction prior to release and connecting them to Center of Excellence upon release. The state's largest OTP Health Home has been contracted by the Department of Corrections to work inside the prison to ensure to smooth transition to the community. BHDDH is also providing Narcan to individuals being released from the DOC who are at risk for overdose. BHDDH has also collaborated with the DOC to provide a nurse care manager in the DOC to assist with MAT, SBIRT, and access to housing through the CABHI grant.

DCYF is responsible for child welfare, juvenile justice programs and behavioral health services for all children in RI. DCYF has the state's only Juvenile Corrections and Detention Facility for youth between age of 13 and 19. DCYF provides Mental health and substance abuse treatment to residents of the Rhode Island Training School plus other educational and vocational programming. There is a Youth Transition Center for high risk youth on probation or leaving the Training School. Services focus on strengthening families by intergrading outreach and tracking services with rehab services. In FY 2017, 129 youth received this service. There are a variety of Diversion Services including a Wayward/Disobedient program that provides assessment and service planning. During FY 2017, 253 youth received services from six community agencies. The youth Diversionary Programs provide

crisis intervention, family mediation, advocacy, counseling and referrals to 312 youth in FY 2017.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ☐ Yes ☐ No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women? ☐ Yes ☐ No
3. Does the state purchase any of the following medication with block grant funds? ☐ Yes ☐ No
 - a) ☐ Methadone
 - b) ☐ Buprenorphine, Buprenorphine/naloxone
 - c) ☐ Disulfiram
 - d) ☐ Acamprosate
 - e) ☐ Naltrexone (oral, IM)
 - f) ☒ Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately? ☐ Yes ☐ No
5. Does the state have any activities related to this section that you would like to highlight?

The state receive a MAT-PDOA grant and is establishing Centers of Excellence (COE). The first year provided start-up costs for 2 hospital based COE and there are currently 2 community based COE with central and northern RI. The COE using the hub and spoke model and has a goal of increasing DATA waived physicians.

Please indicate areas of technical assistance needed to this section.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.⁶⁴ SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁶⁵,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

⁶⁴<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶⁵Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please respond to the following items:

1. Crisis Prevention and Early Intervention

- a) ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning
- b) ☐ Psychiatric Advance Directives
- c) ☒ Family Engagement
- d) ☒ Safety Planning
- e) ☐ Peer-Operated Warm Lines
- f) ☐ Peer-Run Crisis Respite Programs
- g) ☒ Suicide Prevention

2. Crisis Intervention/Stabilization

- a) ☒ Assessment/Triage (Living Room Model)
- b) ☐ Open Dialogue
- c) ☒ Crisis Residential/Respite
- d) ☒ Crisis Intervention Team/Law Enforcement
- e) ☒ Mobile Crisis Outreach
- f) ☒ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- a) ☐ WRAP Post-Crisis
- b) ☒ Peer Support/Peer Bridges

- c) ☒ Follow-up Outreach and Support
- d) ☒ Family to Family Engagement
- e) ☒ Connection to care coordination and follow-up clinical care for individuals in crisis
- f) ☒ Follow-up crisis engagement with families and involved community members
- g) ☒ Recovery community coaches/peer recovery coaches
- h) ☒ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

RI is in the process of creating through the state purchasing process a behavioral health link "BH Link" to address behavioral health crisis across the state and coordinate the state's help lines (overdose, SUD and suicide) providing a resources for all Rhode Island. The BH Link will collaborate with our BH organizations, Opioid Treatment Programs, detox, treatments and the continuum of housing programs.

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|---|--|--|
| • Clubhouses | Peer-run respite services | Whole Health Action Management (WHAM) |
| • Drop-in centers | • Peer-run crisis diversion services | • Shared decision making |
| • Recovery community centers | • Telephone recovery checkups | • Person-centered planning |
| • Peer specialist | • Warm lines | • Self-care and wellness approaches |
| • Peer recovery coaching | • Self-directed care | • Peer-run Seeking Safety groups/Wellness-based community campaign |
| • Peer wellness coaching | • Supportive housing models | • Room and board when receiving treatment |
| • Peer health navigators | • Evidenced-based supported employment | |
| • Family navigators/parent support partners/providers | • Wellness Recovery Action Planning (WRAP) | |
| • Peer-delivered motivational interviewing | | |

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders. Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:
 - a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? j n Yes j n No
 - b) Required peer accreditation or certification? j n Yes j n No
 - c) Block grant funding of recovery support services. j n Yes j n No
 - d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

Yes, Rhode Island participated in a SAMHSA program to develop our peer recovery specialist certification through BRSSSTACS. This included peers, community based organizations and advocates. 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 in the near future.
2. Does the state measure the impact of your consumer and recovery community outreach activity? j n Yes j n No
3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

The Department is implementing a Health Transitions grant which is establishing youth voices and a youth move initiative. Peer recovery specialists are being certified to work in a variety of specialties including mental illness, homelessness, re-entry, older adults, pregnant women with SUD. Peer Recovery Specialist are part of the Integrated Health Home and ACT teams and providing recovery support services throughout the state.
4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

The Department is implementing a State Youth Treatment Planning grant and will be administering an implementation grant in the fall which is establishing youth voice and creating programs that address gaps in the system. Peer recovery specialists are being certified to work in a variety of specialties including homelessness, re-entry, older adults, pregnant women with SUD. Peer Recovery Specialist work in the community at Recovery Centers, there will soon be three located across the state. There is a peer recovery program in emergency departments to engage individuals who have overdosed and teams to are providing mobile outreach to data identified "hot spots". Peers are also working with the statewide Help Line and organize the Rally for Recovery every September.
5. Does the state have any activities that it would like to highlight?

The State has received national recognition for its work with peer recovery specialist on the overdose crisis through the Anchor ED program and the Anchor MORE (mobile outreach program). The state is starting to work with pregnant and parenting peers who have substance use disorders and/or opioid use disorders and have lost their children to the state. The hope is to reach women prior to delivery.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights ([OCR](#)) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state's Olmstead plan include :

housing services provided.	<input checked="" type="radio"/> Yes <input type="radio"/> No
home and community based services.	<input checked="" type="radio"/> Yes <input type="radio"/> No
peer support services.	<input checked="" type="radio"/> Yes <input type="radio"/> No
employment services.	<input checked="" type="radio"/> Yes <input type="radio"/> No
2. Does the state have a plan to transition individuals from hospital to community settings? ☒ Yes ☐ No
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

RI does not have an Olmstead Plan. The Governor's Council on Behavioral Healthcare requested that the Governor create a work group to create a plan and BHDDH has been charged with created a plan for Behavioral Health. We are in the process of working with the Council on an outline and developing a timeframe for its creation. Our plan will include housing, employment, home and community based services and peer supports.

Does the state have any activities related to this section that you would like to highlight?

The state applied for and received an 811 grant from the Department of Housing and Community Development with RI Housing as the lead. The units are coming on line and we will have 150 units integrated into the community for the BHDDH population, homeless population and individuals in nursing homes.

In 2013 BHDDH participated in the SAMHSA Olmstead Policy Academy, however, the previous administration decided we did not need an official plan.

Please indicate areas of technical assistance needed related to this section.

We may need assistance in this area.

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community⁶⁶. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24⁶⁷. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death⁶⁸.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21⁶⁹. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs⁷⁰.

According to data from the 2015 Report to Congress⁷¹ on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

⁶⁶Centers for Disease Control and Prevention. (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁷Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁶⁸Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁶⁹The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁷⁰Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMH12010>

⁷¹http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

- Does the state utilize a system of care approach to support:
 - The recovery and resilience of children and youth with SED? ☐ Yes ☐ No
 - The recovery and resilience of children and youth with SUD? ☐ Yes ☐ No
- Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:
 - Child welfare? ☐ Yes ☐ No
 - Juvenile justice? ☐ Yes ☐ No
 - Education? ☐ Yes ☐ No
- Does the state monitor its progress and effectiveness, around:
 - Service utilization? ☐ Yes ☐ No
 - Costs? ☐ Yes ☐ No
 - Outcomes for children and youth services? ☐ Yes ☐ No
- Does the state provide training in evidence-based:
 - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ☐ Yes ☐ No
 - Mental health treatment and recovery services for children/adolescents and their families? ☐ Yes ☐ No
- Does the state have plans for transitioning children and youth receiving services:
 - to the adult behavioral health system? ☐ Yes ☐ No
 - for youth in foster care? ☐ Yes ☐ No
- Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)
 DCYF provides child welfare services and juvenile justice services. At the RI Training School, DCYF is responsible for providing educational services and works for DOE. Through the system of care that has been developed over the past fifteen years, the process for accessing services based on functional assessments, family planning, being culturally and linguistically sensitive, and involving families and youth in the process has reinforced the need to coordinate services and to collaborate to ensure that child/youth receive what they need. Substance use treatment is coordinated through the health insurance. Most youth in RI have medical coverage. there are numerous work project for integrating services for children and work through coordination of both state agencies and community providers. Most youth in out of home placement have a diagnosis and need treatment. There is a high incidents of neglect, abuse, substance use, trauma, domestic violence and environment factors such as housing issues, educational issues, vocational issues noted in the population of child welfare and juvenile justice.
- Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ☒ Yes ☐ No

2. Describe activities intended to reduce incidents of suicide in your state.

The most recent Rhode Island 5-year Suicide Prevention Plan included the years 2011 through 2016, however the plan was not enacted until 2013. The 2017-2022 plan has been in development for several months including program staff review, key stakeholder interviews, public input panels, and current review for alignment with the 2012 National Strategies for Suicide Prevention. This plan is expected to be presented to the Governor's Council on Behavioral Health in the coming months for review before final approval by the Injury Community Prevention Group to be included in the Department of Health's, Statewide Violence and Injury Prevention Plan.

3. Have you incorporated any strategies supportive of Zero Suicide? ☒ Yes ☐ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ☒ Yes ☐ No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? ☒ Yes ☐ No

If so, please describe the population targeted.

The Department of Health's Suicide Prevention Program has participated in a nine-month Community of Practice on Zero Suicide in Healthcare Systems with staff from Butler Hospital, a psychiatric hospital for adults and young adults. The RIDOH team has also participated on Zero Suicide planning/training teams for two of the state's largest health systems, Lifespan, Inc. and Care New England, Inc., to include increase screening within hospital systems, inclusion of suicide screening in the electronic health record, and post-discharge care planning.

Through the Department of Health's Suicide Prevention Initiative, youth discharged from Bradley Hospital's Inpatient or the Hasbro Children's Hospital Emergency Department could be enrolled in the SPI follow up tracking, including follow up contacts by the Bradley Hospital Access Center at 2 weeks, 3 months, and one year following discharge. Other care transition initiatives are taking place through research related functions by Brown University/Butler Hospital Teams under NIMH funded research projects such as CLASP, SPIRIT, and ED-SAFE studies.

<https://www.ncbi.nlm.nih.gov/pubmed/27038050>

<https://www.nimh.nih.gov/news/science-news/2015/embracing-the-spirit-of-reducing-suicide.shtml>

<https://www.nimh.nih.gov/news/science-news/2017/emergency-departments-could-play-significant-role-in-reducing-suicide-attempts.shtml>

RISPP has developed two new initiatives designed to target 18-24 years old residents of Rhode Island.

The first focuses on creating a state-wide advisory group of representatives from all RI colleges and universities that will focus exclusively on suicide prevention on college campuses. This group will work collaboratively to share resources and lessons learned to create a more universal approach to preventing suicides on RI college campuses.

The second focuses on engaging individuals ages 18-24 who are currently in the workforce and not involved in a higher education setting. This outreach will be executed via training and resources offered through employers' Employee Assistance Programs as well as the RI Department of Health's Occupational and Safety Health Administration (OSHA) Consultation program, whose personnel already consult with employers about workplace safety and will now include suicide prevention resources/training as part of their work.

Does the state have any activities related to this section that you would like to highlight?

The SPI protocol currently implemented in seven RI school districts inclusive of nearly 50,000 students' grades K-12 (with two more to be added in the coming year), is the first universal suicide screening and referral protocol implemented in Rhode Island and has

greatly exceeded expectations in regards to effectiveness and adoption by school officials. Additionally, RISPP staff are collaborating with the RI Department of Administration and the State Employee health insurer (United Healthcare), to offer financially incentivized suicide prevention "gatekeeper" training to all state employees covered under the State's health insurance plan (12,700+ employees). If enacted, this is expected to result in a minimum of 6,000 additional individuals trained as suicide prevention "gatekeepers" in RI, which will triple the number of individuals trained as a result of efforts from RISPP.

Please indicate areas of technical assistance needed related to this section.

Not at the moment.

Footnotes:

2017-2021 Violence & Injury Prevention State Plan

Suicide/Suicide Attempt Prevention Section

Suicide and suicide attempts continue to persist as serious public health problems with devastating effects on the victims, survivors (family/friends of the deceased), and communities. Suicide and suicidal ideation can affect individuals of all ages, races, and socio-economic backgrounds, stressing the need for a comprehensive approach to reducing suicidal behavior in Rhode Island. In 2015, suicide was the 12th leading cause of death overall in Rhode Island for all age groups, and the 2nd leading cause of death for individuals ages 15-34.¹

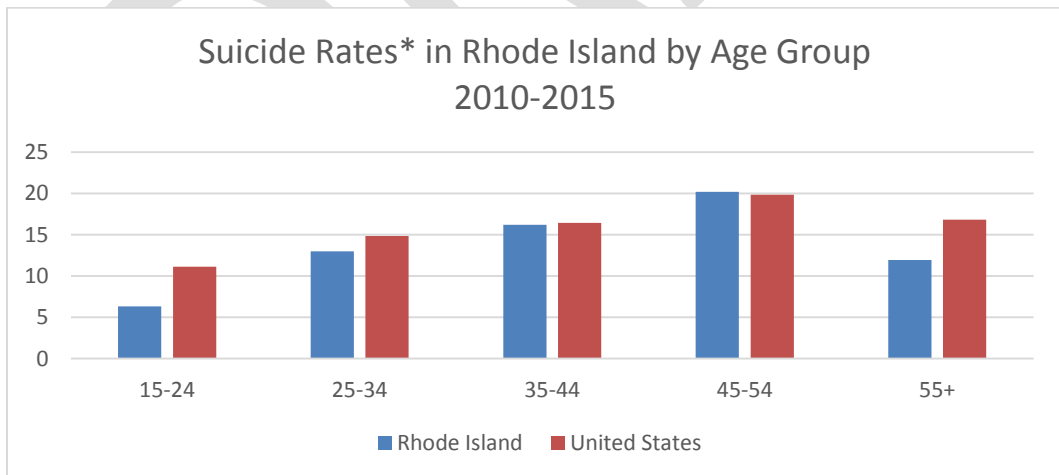
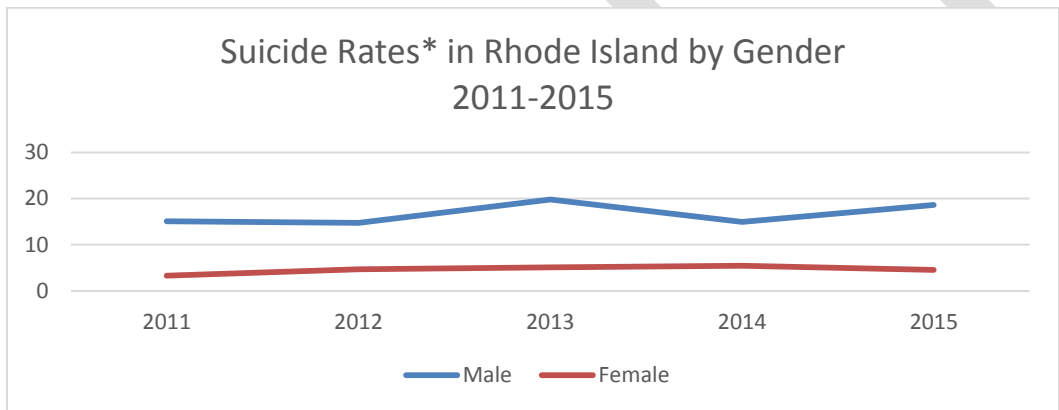
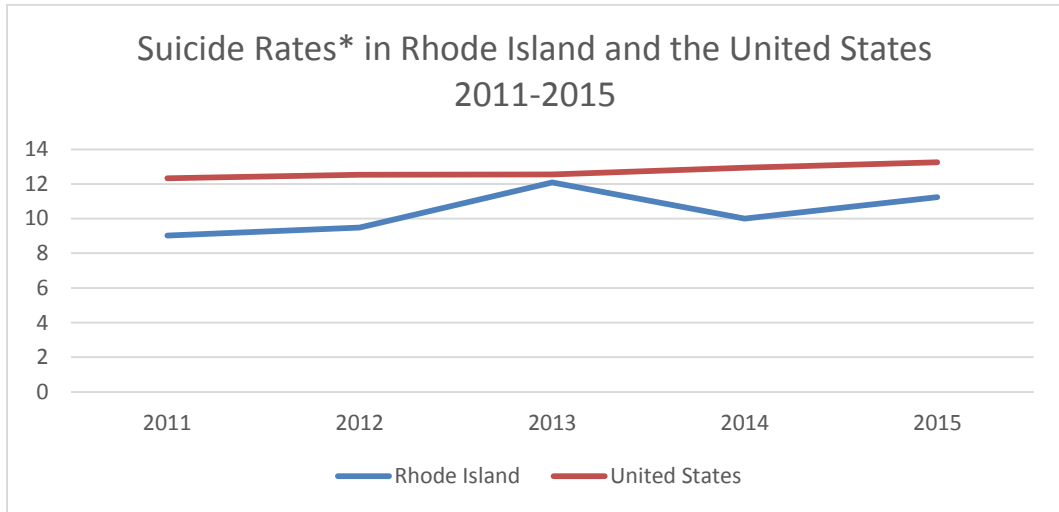
In 2015 there was 127 suicide deaths in Rhode Island², however, these deaths only represent a fraction of the impact of suicidal behavior among RI residents. Non-fatal injuries from suicide attempts are much more common than death by suicide. The Rhode Island Department of Health uses an inpatient hospital admission or an emergency department visit coded as resulting from 'self-harm' injury as a marker for suicide attempt.

In Rhode Island, the current rate of 12 deaths by suicide per 100,000 residents in 2015 represents a 62% increase from the previous rate of 7.4 per 100,000 in 2004.³ Among those who died by suicide in 2015 the majority were males (79%).² Examining the overall suicide rate for Rhode Island from 2010 to 2015, it is evident that adults age 45-54 were more likely to die by suicide in comparison to all other age groups during that time period.⁴

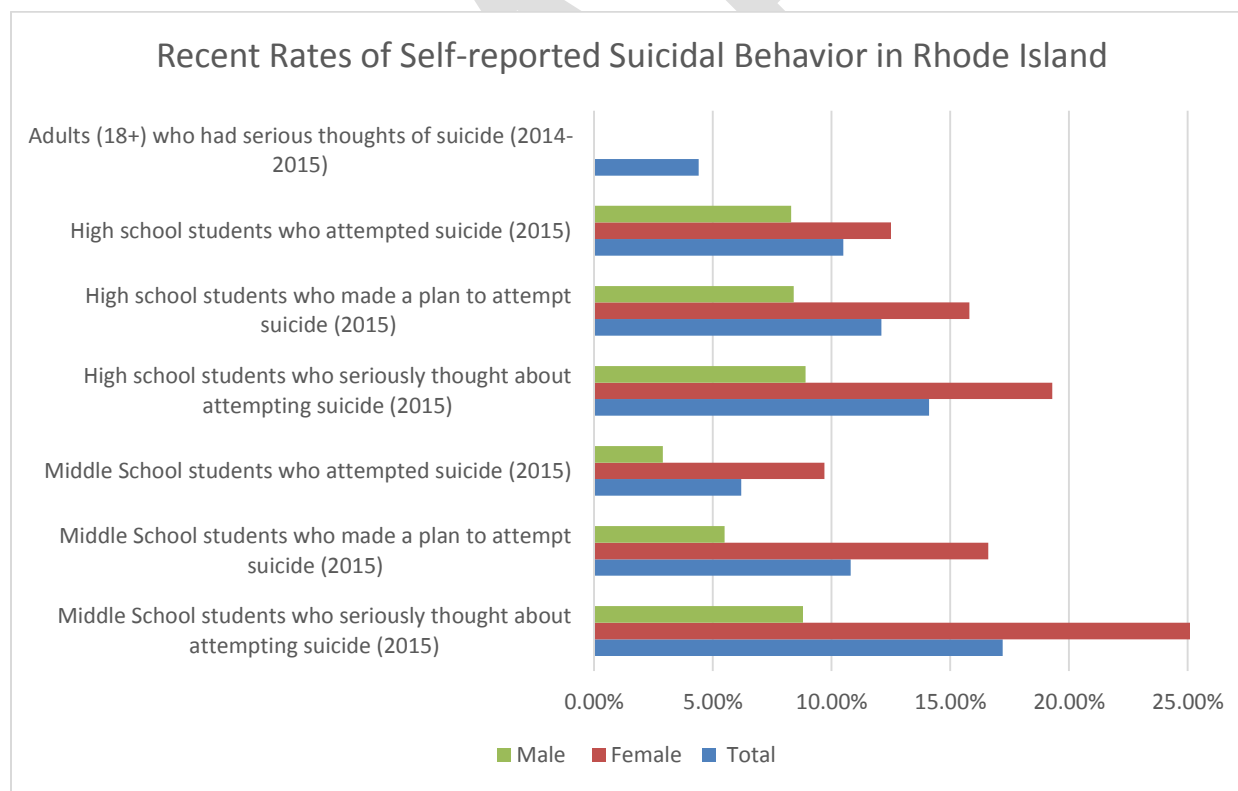
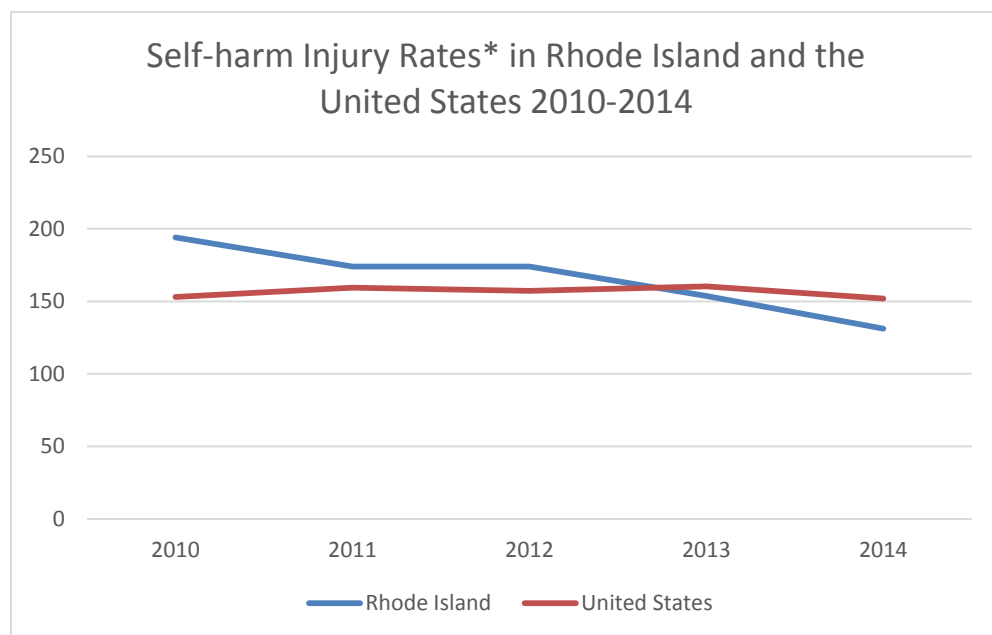
The prevalence of suicidal ideation in youth and adults in Rhode Island is primarily gathered through self-reported data sources such as the Youth Risk Behavior Survey and the National Survey on Drug Use and Health. It is alarming to see that in 2015, 17.2% of RI middle school students reported having serious thoughts about suicide, with 14.1% of RI high school students also reporting serious thoughts of suicide.⁵ From 2010-2014 Rhode Island saw an overall decrease in its rates of encounters resulting from a suicide attempt in RI hospital emergency departments and in-patient facilities.⁶ Since it has been shown that suicide rates are correlated with economic recession periods⁷ this reduction in suicide attempts may be partially attributed to the recovery from the 2008 U.S financial crisis.

In the United States, non-Hispanic Native Americans/Alaska Natives and non-Hispanic whites continue to have the highest age-adjusted rates of death by suicide (19.98/100,000 and 16.95/100,00, respectively).² The lowest rate of death by suicide is attributed to the Hispanic-black population, with an overall age-adjusted rate of 2.03/100,000.²

Rhode Island Suicide Deaths



Rhode Island Suicidal Behavior



* All asterisked rates are age-adjusted using published Centers for Disease Control and Prevention methodology to ensure the differences in incidences or deaths from one year to another, or between one geographic and another, are not due to differences in the age distribution of the populations being compared.

Goals

Goal 1: Prevent suicides among Rhode Island residents.

Goal 2: Prevent suicide attempts among Rhode Island residents

Recommendations:

1. Increase screening and identification of Rhode Islanders who are at risk of death from suicide and refer them to appropriate clinical services.
2. Work to reduce the stigma associated with having a mental illness and/or seeking services for mental health and substance abuse issues.
3. Improve and expand mental health service delivery.
4. Promote efforts to reduce access to lethal means and methods that result in self-harm or a suicide attempt.
5. Coordinate and expand public health surveillance of suicide and suicide attempts.

Priority Populations:

- All ages (life-course approach)
- Youth ages 15 through 24
- Individuals currently receiving care for mental health and/or substance use disorders
- Military veterans

Risk Factors:

Suicide and suicidal ideation can affect people from all walks of life, regardless of socio-economic status, cultural background, or any other identifying feature that public health professionals normally use to classify different populations. However, there are some population groups known to be at higher risk for suicide than the general population and they include but are not limited to:

- American Indian and Alaska Natives
- People bereaved by suicide
- People in criminal justice and child welfare settings
- People who intentionally hurt themselves (non-suicidal self-injury)
- People who have previously attempted suicide
- People with medical conditions
- People with mental health and/or substance use disorders
- People who are lesbian, gay, bisexual, or transgender
- Members of the military and veterans
- Men in midlife and older men⁸

Evidence-based Interventions:

The U.S Substance Abuse and Health Services Administration (SAMHSA) defines evidence-based interventions as those that fall into one or more of three categories:

1. The intervention is included in a federal registry of evidence-based interventions, such as the National Registry of Evidence-based Programs and Practices (NREPP) **OR**
2. The intervention produced positive effects on the primary targeted outcome, and these findings are reported in a peer-reviewed journal **OR**
3. The intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence should be implemented under four recommended guidelines, all of which must be followed, these guidelines require interventions to be:
 - a. Based on a theory of change that is documented in a clear logic or conceptual model **AND**
 - b. Similar in content and structure to interventions that appear in federal registries of evidence-based interventions and/or peer-reviewed journals **AND**
 - c. Supported by documentation showing it has been effectively implemented in the past, multiple times, and in a manner attentive to scientific standards of evidence. The intervention results should show a consistent pattern of credible and positive effects. **AND**
 - d. Reviewed and deemed appropriate by a panel of informed prevention experts that includes qualified prevention researchers experienced in evaluating prevention interventions similar to those under review; local prevention professionals; and key community leaders, as appropriate (for example, law enforcement officials, educators, or elders within indigenous cultures).

In order for a public health intervention to have a greater chance of success in reducing rates of suicide and suicide attempts in a community, not only must the intervention be evidence-based, but it must be the right “fit” for the targeted population. Also, interventions have a much higher rate of success when addressing both factors that can lead to suicidal behavior: risk and protective factors. The presence of multiple risk factors increases the probability of suicidal ideation and behavior while the presence of multiple protective factors reduces this probability. Comprehensive suicide prevention programs both reduce risk factors and increase protective factors.

One approach to suicide prevention is gatekeeper training. Signs of Suicide (SOS) is an evidence-based, school-based gatekeeper program. It is designed for middle and high school-age students. The program teaches students how to identify the symptoms of depression and suicidality in themselves or their friends and encourages help-seeking through the use of the ACT technique (Acknowledge, Care, Tell).¹¹

Another evidence-based gatekeeper program is Question, Persuade, and Refer (QPR). This one- to two-hour educational program is designed to teach adult gatekeepers to recognize the warning signs of a suicide and how to respond.¹² Adult gatekeepers (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, police officers) are strategically positioned to recognize and refer someone at risk of suicide. QPR has been shown to successfully teach workshop participants suicide specific skills; however, the program does not evaluate participants’ actual use of those skills.¹³

The Violence and Injury Prevention Program (VIPP) uses a life-course approach including evidence-based gatekeeper programs and media campaigns such as Suicide Proofing Your Home (www.suicideproof.org) for suicide prevention. Early intervention and education about the signs of suicide provide at-risk youth and their mentors the tools and information to identify suicide risk and to seek and/or refer to appropriate help. The VIPP will continue to support statewide partners in the implementation of SOS and QPR throughout the duration of this Plan.

Recommendations and Associated Objectives

Recommendation 1: Increase screening and identification of Rhode Islanders who are at risk of death from suicide and refer them to appropriate clinical services.

Objectives:

- 1.1: Throughout the duration of the Plan, seek out additional federal, state and private funding that increases the availability of evidence-based suicide prevention education/training programs in organizations and places where individuals and families congregate (e.g. schools, faith-based organizations, community groups, etc.).
- 1.2: Annually provide evidence-based suicide prevention “gatekeeper” trainings to community organizations, including but not limited to: schools, faith-based organizations, community action groups, LGBTQQ organizations, homeless shelters, and parent-teacher organizations.
- 1.3: By 2021, work with RI higher education officials to embed or enhance evidence based suicide prevention/mental health training in curricula for human resources and business management programs in at selected Rhode Island colleges/universities.
- 1.4: By 2021, train emergency medical technicians from different RI towns/cities to recognize individuals in a mental health crisis and notify hospital emergency room staff of the need for a mental health assessment when appropriate.
- 1.5: Every two years or as often as funding allows, provide a Continuing Medical Education course for physicians that includes the topic of suicide and suicide prevention as a key aspect of the training.
- 1.6: By 2019, create and publish a RI Department of Health (RIDOH) Policy Recommendation requiring all primary care physicians to conduct basic mental/behavioral health screenings using evidence-based tools.
- 1.7: By 2019, develop an adaptable response protocol for Rhode Island police officers to use when encountering individuals who are experiencing suicidal ideation and/or mental health crisis in all applicable settings (i.e. schools, normal patrols, social media posts, etc.).
- 1.8: By 2021, collaborate with the Rhode Island Executive Office of Health and Human Services’ Office of Medicaid to create and implement a reimbursable billing code for primary care physicians to conduct mental health screenings.
- 1.9: Encourage all RI-based groups involved in suicide prevention to participate in the Annual Primary Care Conference held by the RI Academy of Family Physicians and distributes informational resources and/or conduct a presentation to attendees.
- 1.10: By 2019, create and publish a RI Department of Health Policy Recommendation that supports the creation of legislation requiring evidence-based suicide prevention education/training for all Rhode Island first-responders not already required to do so (EMTs, fire fighters, etc.).

- 1.11: By 2021, establish a partnership between the RI Department of Health and United Way of Rhode Island to ensure that current mental/behavioral health resources are made available to 211 staff to share with their clients.
- 1.12: Throughout the duration of the Plan, ensure a list of local mental/behavioral health resources is made available online and other available communication channels to all Rhode Island “gatekeepers” trained in evidence-based suicide prevention techniques.
- 1.13: By 2021, work with the Rhode Island Executive Office of Health and Human Services’ Office of Medicaid to enhance EPSDT (Early and Periodic Screening, Diagnosis and Treatment) mental/behavioral health services covered by RI’s Medicaid program.

Recommendation 2: Work to reduce the stigma associated with having a mental illness and/or seeking services for mental health and substance abuse issues.

Objectives:

- 2.1: By 2021, work with the RI Department of Education (RIDE) to incorporate evidence-based education on mental illness in RI public schools’ health education curriculums to help reduce stigma among students.
- 2.3: Over the next five years, provide support to existing mental health peer-support groups providing services around substance abuse, suicide loss, depression, and other relevant topics by promoting their meetings and services via the RIDOH website, RIDOH publications, and other established communication systems (newsletters, listservs, etc.).
- 2.4: Over the next five years, work to identify geographical locations within RI with a lack of mental health peer-support groups and share this information with the RI Substance Use and Mental Health Leadership Council.
- 2.5: By 2019, ensure that all suicide prevention resources targeted at Rhode Island residents include a current list of local and community resources in Rhode Island that is maintained and updated regularly by the RI Department of Health.
- 2.6: Throughout the duration of the Plan, develop and disseminate culturally sensitive and engaging public messaging to raise awareness of suicide among RI adults as a public health issue that is preventable through early actions of individuals and communities.
- 2.7: Annually conduct a review of a representative sample of Rhode Island media coverage concerning suicide for adherence to the American Foundation for Suicide Prevention’s Recommendations for Reporting on Suicide, note any that fall out of compliance and provide the publishing organization a copy of the recommendations as well as rationale for complying with them.
- 2.9: By end of 2019, design and make available new youth-friendly informational resources in English and Spanish on suicide and suicide prevention to all Rhode Island school districts, family physicians, and other relevant stakeholders.
- 2.10: By 2021, engage all Rhode Island colleges/universities on the importance of offering specific resources on suicide prevention and having a plan to refer students in a mental health crisis to appropriate clinical services.
- 2.11: By 2021, obtain a letter of intent from the senior administration of at least one major health care system in Rhode Island to implement a Zero Suicide framework across all of their associated facilities/practices within 3 years of the letter being signed.
- 2.12: Throughout the duration of the Plan, use the RIDOH and the RI Department of Behavioral Health Developmental Disabilities and Hospitals (BHDDH) websites to increase the visibility of education/support programs designed to assist families who have members suffering from

mental illness and use established communication channels to disseminate information on these programs to all Rhode Island mental/behavioral health clinicians.

Recommendation 3: Improve and expand mental health service delivery.

Objectives

- 3.1: By 2020, create and publish an informational report that details how increased Medicaid reimbursements for mental health services are linked to enhanced mental health outcomes for consumers and increased access to mental health services and share this information with the RI Executive Office for Health and Human Services' Office of Medicaid.
- 3.2: Over the next five years, seek out federal, state, or private funding to establish a mental health emergency department diversion program for adults entering RI emergency departments with mental/behavioral health issues and/or substance use disorders.
- 3.3: By 2019, work with Substance Use and Mental Health Leadership Council and/or BHDDH to re-establish the monthly meetings of Rhode Island community mental health centers and other relevant stakeholders with the goal of coordinating mental health care across RI and fulfilling relevant objectives of this Plan.
- 3.4: By 2021, collaborate with BHDDH to develop a navigational framework for behavioral/mental health care providers, with SBIRT (Screening, Brief Intervention, Referral and Treatment) professionals embedded in all of RI's community health centers.
- 3.6: Beginning in 2017, work with appropriate staff within the RI Executive Office of Health and Human Services to identify existing feasible insurance reimbursement mechanisms for behavioral/mental tele-medicine services.
- 3.7: By 2020, work with CurrentCare Rhode Island to expand the number of mental/behavioral health clinicians that regularly submit relevant patient data to the CurrentCare system.
- 3.8: Work with RI graduate and medical programs to promote state loan repayment programs to recently graduated Rhode Island mental/behavioral health clinicians who are willing to work in identified Mental Health Service Provider Shortage Areas within Rhode Island.
- 3.9: To better serve the substantial Latino(a)/Hispanic population in Rhode Island, work with RI - based healthcare systems to continuously recruit Spanish-speaking mental/behavioral clinicians using incentives such as the Rhode Island Health Professionals Loan Repayment Program.
- 3.10: By 2021, create a visual map of the administration structure for mental/behavioral health services for the State of Rhode Island that creates a clear vision, guidelines for provider organizations, and clear delineation of responsibilities among State agencies.
- 3.11: By 2019, propose a change to the current RI Rules and Regulations for Licensing Mental Health Counselors and Marriage and Family Therapists (R5-63.2-MHC/MFT) that requires suicide prevention education as a pre-requisite for licensure for all mental health providers.
- 3.12: Throughout the duration of the Plan, work with the Rhode Island Chapter of the National Alliance on Mental Illness to promote existing support services and groups for families of those suffering from a mental illness and/or suicidal ideation.
- 3.13: By 2021, create and disseminate an informational packet of mental/behavioral health resources consisting of hotlines, mental/behavioral health providers' information, and screening tools to all Rhode Island medical providers.
- 3.14: By 2021, educate and inform policy makers on the need to expand student assistance programs to all Rhode Island public middle and high schools.

- 3.15: Beginning in 2017, research and document feasible insurance reimbursement mechanisms for provision of counseling services in Rhode Island middle and high schools as a way to ensure consistent funding for these services in RI schools.

Recommendation 4: Promote efforts to reduce access to lethal means and methods that result in self-harm or a suicide attempt.

Objectives

- 4.1: Annually provide evidence to relevant Rhode Island Department Directors on the effectiveness of reducing suicide rates through comprehensive firearm safety policies.
- 4.2: Throughout the duration of the Plan, raise awareness of current firearm-safety laws under RI General Law Chapter 11-47 “Weapons”, and by promoting locations that provide free resources to comply with current laws (gun-locks, etc.) via firearm vendors, shooting ranges, and the RIDOH website.
- 4.3: By 2019, provide all RI licensed peer-recovery service organizations and medical provider organizations with information on how substance abuse and other high-risk behaviors are linked to suicide as well as existing evidence-based training opportunities for counselors so they can recognize suicidal ideation in their clients.
- 4.4: By 2019, establish a work group of stakeholders from a variety of healthcare, public safety and community organizations, with the purpose of developing an implementation plan for incorporating counseling on access to lethal means (CALM) training into all relevant settings.
- 4.5: Throughout the duration of the Plan, research and provide evidence to Rhode Island legislators on the effectiveness of using “blister packaging” for over the counter and prescription drugs as a way to discouraging their use as lethal means.
- 4.6: Annually provide suicide prevention resources and/or training to firearm dealers/store employees/owners that helps them identify actively suicidal customers and take actions consistent with statutory authority.
- 4.7: Throughout the duration of the Plan, coordinate with the U.S Drug Enforcement Agency (DEA) to promote the use of take-back days to dispose of prescription/illicit drugs at designated appropriate locations in Rhode Island (police stations, fire departments, pharmacies, etc.)
- 4.8: Throughout the duration of the Plan, work with the Rhode Island Office of the Health Insurance Commissioner to examine Rhode Island health insurers’ policies regarding 90-day supplies of prescription medications as an effort to reduce suicide attempts and make new recommendations to all RI health insurers regarding patient prescription supplies.
- 4.9: By 2019, establish a partnership with the Regional Center for Poison Control and Prevention to ensure their frontline staff receive suicide prevention training and that they offer information on suicide/suicide prevention on their website.

Recommendation 5: Coordinate and expand public health surveillance of suicide and suicide attempts.

Objectives

- 5.1: Annual review peer-reviewed literature for new and emerging suicidal ideation screening tools and evaluate their potential for use in various settings throughout Rhode Island.
- 5.2: By the end of 2018, publish a report that includes all current sources of suicides and suicide attempt data as well as any current data gaps that should be addressed.
- 5.3: By 2019, establish memorandums of understanding with all applicable state agencies so that the Department of Health receives de-identified data on suicide attempts by individuals under their care/jurisdiction.
- 5.4: By 2019, identify and implement a feasible method to incorporate reports on suicide attempts into various first-responder report systems where it is not already included (i.e. EMTs, police, fire fighters, etc.).
- 5.5: By 2019, submit new regulations requiring first-responders to identify suicides and/or suicide attempts correctly on relevant reporting mechanisms as well as appropriate training (i.e. EMS logs, police reports, etc.).
- 5.6: By 2021, establish an Adult Death Review Team with the purpose of examining all adult suicides that take place in Rhode Island and their underlying causes.
- 5.7: Throughout the duration of the Plan, provide education to Rhode Island school administrators on the value of asking students about suicidal ideation/behavior while using peer-reviewed literature to demonstrate that there is no proven harm in asking these questions.
- 5.8: Annually conduct a health disparities evaluation of populations in Rhode Island to clarify which groups are at a higher risk of death by suicide/suicide attempts, classify these populations by as many criteria as possible (gender, sexual orientation, etc.).
- 5.9: Annually review the incidence of intentional poisonings in Rhode Island that result from use of illicit and legal drugs/medications for trends that can be quantified and addressed.
- 5.10: Annually review national suicide data to target occupations who have a higher risk of suicidal ideation and provide information on mental illness and suicide prevention to those occupations through their interactions with State agencies (licensing, permitting, etc.).

References:

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<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=53>.
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13. Cross W, Matthieu MM, Lezine D, Knox KL. Does a brief suicide prevention gatekeeper training program enhance observed skills? *Crisis*. 2010;31(3):149-59.

Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? j n Yes j n No
2. Has your state identified the need to develop new partnerships that you did not have in place? j n Yes j n No
If yes, with whom?
No new partners were identified.
3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The Executive Office of Health and Human Services is the umbrella organization for the Departments of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), Health (DOH), Children, Youth and Families (DYFC), Human Services (DHS) and the Division of Medicaid. The departments under EOHHS work closely together to address critical issues impacting the State; including the overdose crisis and suicide (BHDDH and DOH), parity (BHDDH, DOH, Office of the Health Insurance Commissioner), Health Homes oversight (Medicaid and BHDDH), adolescents and transition aged youth (BHDDH, DCYF and Medicaid), medication assisted treatment in the Department of Corrections (DOC and BHDDH). EOHHS also received a State Innovations Model grant (SIM) an inter-departmental project with a mission to establish a "multi-sectoral collaborative, based on data—with the patient/consumer/family in the center of our work. Rhode Island SIM is committed to an integrated approach to the physical and behavioral health needs of Rhode Islanders, carried out by moving from a fee-for-service healthcare system to one based on value that addresses the social and environmental determinants of health. These initiatives required that State agencies collaborate in a meaningful way to institute evidence based practices, develop financing models to ensure sustainability and most importantly obtain better outcomes for the people receiving services.

Does the state have any activities related to this section that you would like to highlight?

The SIM project has brought together the agencies under EOHHS to work collaboratively on projects to provide the triple aim: better care, better quality and lower costs. The State departments are collaborating on performance outcomes that include the integration of health and behavioral health care, workforce development and other health related issues that disproportionately impact the mental health and substance use disorder populations.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](http://beta.samhsa.gov/grants/block-grants/resources).⁷²

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

⁷²<http://beta.samhsa.gov/grants/block-grants/resources>

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

- a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

Rhode Island Governor's Council on Behavioral Healthcare meets monthly and includes substance use disorder, primary preventions and mental health. Members represent state agencies, community based programs, advocates, providers, consumers and families. The Governor's Council also includes a Steering Committee that sets agendas to address gaps and issues in the system. Throughout the year the Department presents information to the Governor's Council and gathers input from the group. The application was e-mailed to the Council on 7/31/17 for input, is presenting at the August meeting and has posted the application on the website.

A work group of the Council, the Prevention Advisory committee was instrumental in the creation of a Strategic Prevention Plan which is the basis for our State's Prevention service delivery system.

- b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i ☒ Yes ☐ No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ☒ Yes ☐ No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Governor's Council on Behavioral Healthcare (the Council) is responsible for the following: 1) to review and evaluate the behavioral health needs and problems in the state and propose such recommendations as are appropriate, 2) To stimulate and seek the development and coordination of all programs relating to behavioral health, including but not limited to , such areas as, care and treatment, prevention, manpower, research and public education; 3)To encourage interdisciplinary approaches to combating, treating and preventing substance use disorders and mental illness, focusing in particular on integrating support systems for behavioral healthcare, 4) to act as an advisory council to BHDDH, and the Governor on any funds made available by the federal government for substance use disorder, mental health treatment and prevention purposes, 5)To stimulate and investigate research as it affects planning and implementation of behavioral health care systems in the health care environment; 6) To make an annual report to the Governor and General Assembly in the month of January.

The Council represents RICARES, Anchor, PSN MHA, MHCA and as part of our on-going needs assessment this information is collected at the community level, the SEOW present annually and data requested can be made by our data unit.

Does the state have any activities related to this section that you would like to highlight?

The work of the SEOW. this work group is made up of epidemiologist from the Departments of Health. Children Youth and

Families and evaluators from Brown University and the University of Rhode Island. The work initially began as part of the Partnership for Success grant and has focused on predominantly on prevention but is expanding into treatment. Rhode Island has certified Peer Recovery Specialists and have integrated them into integrated health homes, the response to overdose, the housing and homeless system and other recovery supports.

Please indicate areas of technical assistance needed related to this section.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.⁷³

⁷³There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Nicole Alexander-Scott	State Employees	Rhode Island Department of Health		
Richard Antonelli	Others (Not State employees or providers)		139 Lansdown Rd. Warwick RI, 02888 PH: 401-000-0000	
Eric Bean	State Employees			
Rebecca Boss	State Employees	Rhode Island of Behavioral Healthcare, Developmental Disabilities and Hospitals		
Linda Bryan	Parents of children with SED		485 Weaver Hill Rd W. Greenwich RI, 02817	
Anatoly Burke	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Megan Clingham	Leading State Experts	Mental Health Advocate		
Sandra Delsesto	Leading State Experts	Rhode Island College	600 Mt. Pleasant Ave Providence RI, 02908 PH: 000-000-0000	
Sarah Dinklage	Providers	Rhode Island Student Assistance Program	300 Centerville Road Warwick RI, 02886	
Ruth Feder	Providers	Mental Health Association of Rhode Island	345 Blackstone Boulevard Providence RI, 02906	
Mark Fields	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		8 George St. Pawtucket RI, 02860 PH: 401-000-0000	
Courtney Hawkins	State Employees	rhode island department of human services	57 howard avenue cranston RI, 02920 PH: 401-462-5300	courtney.hawkins@dhs.ri.gov
Richard Leclerc	Others (Not State employees or providers)		RI,	
Wendy Looker	Providers			
Jim McNulty	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	mental health consumer advocates of rhode island	1280 north main street providence RI, 02904 PH: 401-831-6937	
Ann Mulready	Leading State Experts	Rhode Island Disability Law Center	349 Eddy Street Providence RI, 02903	

			PH: 401-000-0000	
George O'toole	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	anchor recovery center	249 main street pawtucket RI, 02680 PH: 401-739-1262	
Trista Piccola	State Employees	Rhode Island Department for Children, Youth and Families		
Esther Picon	Parents of children with SED	parent support network of rhode island	535 centreville road warwick RI, 02886 PH: 401-467-6855	
David Spencer	Providers	Drug and Alcohol Treatment Association of RI	206 West Exchange Street Providence RI, 02903 PH: 401-521-5759	
Brian Sullivan	Providers	operation stand down	1010 hartford avenue johnston RI, 02919 PH: 401-383-4750	
Michael Tondra	State Employees	Office of Housing and Community Development	One Capitol Hill Providence RI, 02906 PH: 401-222-7901	Michael.Tondra@DOA.ri.gov
Kenneth Wagner	State Employees	Rhode Island Department of Education		
A.T. Wall	State Employees	Rhode Island Department of Corrections		

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	21	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	4	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED*	2	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	2	
Total Individuals in Recovery, Family Members & Others	8	
State Employees	8	
Providers	5	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	13	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Many of the provider agencies listed also are individuals in recovery or families members of individuals in recovery; however, the table to describe members does not allow for the selection of more than one category. During the 2017 legislative session, the RI General Assembly passed a bill amending membership of the Governor's Council on Behavioral Health. In addition to technical amendments, the bill increases membership from 26 to 31 and specifies that 2 of the additional 5 public members include the State's Child Advocate and children with behavioral health challenges or their representatives. The Steering Committee of the Council will convene in September, 2017 to make recommendations to the Governor regarding these positions.

Footnotes:

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2017

A N A C T

RELATING TO BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND
HOSPITALS -- GOVERNOR'S COUNCIL ON BEHAVIOR HEALTH

Introduced By: Senators Calkin, Miller, Goldin, Sosnowski, and Satchell

Date Introduced: March 09, 2017

Referred To: Senate Health & Human Services

(Dept. of BHDDH)

It is enacted by the General Assembly as follows:

1 SECTION 1. Sections 40.1-29-2, 40.1-29-3, 40.1-29-4, 40.1-29-5 and 40.1-29-6 of the
2 General Laws in Chapter 40.1-29 entitled "Governor's Council on Behavioral Health" are hereby
3 amended to read as follows:

4 **40.1-29-2. Legislative purpose.**

5 The purpose of the council is to advise the governor and general assembly on policies,
6 goals and operations of the behavioral health program, including the program areas of substance
7 ~~abuse~~ use disorder and mental health, and on other matters the director of ~~mental health,~~
8 ~~retardation,~~ behavioral healthcare, developmental disabilities and hospitals refers to it and to
9 encourage public understanding and support of the behavioral health program.

10 **40.1-29-3. Members.**

11 (a) The council shall consist of ~~twenty-six (26)~~ thirty-one (31) voting members.

12 (1) There shall be four (4) members of the legislature, two (2) shall be from the senate
13 and shall be appointed by the ~~lieutenant governor~~ senate president to serve for their legislative
14 term, one from each of the major political parties, and two (2) shall be from the house of
15 representatives and shall be appointed by the speaker to serve for their legislative term, one from
16 each of the two (2) major political parties.

17 (2) The non-legislative members shall be the executive director of the ~~Drug and Alcohol~~
18 ~~Treatment Association, the executive director of the Council of Community Mental Health~~

1 ~~Organizations~~ Substance Use and Mental Health Leadership Council of RI, the mental health
2 advocate, the child advocate and a representative of the AFL-CIO to be appointed by the
3 governor.

4 (3) The remaining ~~eighteen (18)~~ twenty-three (23) public members shall be appointed by
5 and serve at the pleasure of the governor and shall represent such community interests as
6 substance ~~abuse~~ use disorder treatment and prevention professionals, youth with behavioral health
7 challenges or their representatives, consumers of substance ~~abuse~~ use disorder programs and their
8 families, mental health treatment professionals, adult and elderly consumers of mental health
9 services and their families, families of children who are consumers of mental health and
10 substance abuse services, the judiciary, criminal justice officials and local government officials.

11 (4) Not less than fifty (50%) percent of the public members shall be individuals who are
12 not state employees or providers of behavioral health services.

13 (5) There shall be sufficient representation by the families of children who are consumers
14 of mental health and substance ~~abuse~~ use disorder services in order to ensure adequate
15 representation of such children.

16 (6) Every effort shall be made to ensure that appointed members represent the cultural
17 diversity of the state.

18 (7) All members shall have demonstrable expertise in, or experience with substance
19 ~~abuse~~ use disorders or mental health services in Rhode Island. In addition, the directors or their
20 designees of the departments of children, youth, and families; corrections; education; health;
21 human services; ~~elderly affairs and mental health, retardation,~~ behavioral healthcare,
22 developmental disabilities and hospitals and the division of elderly affairs; the attorney general or
23 designee and the executive director of the Rhode Island justice commission shall serve as ex
24 officio and without a vote as members of the council.

25 (b) Any vacancy which may occur in the council shall be filled in the same manner as the
26 original appointments.

27 (c) The governor shall designate one member as the chairperson of the council.

28 **40.1-29-4. Meetings.**

29 The council shall meet at least six (6) times a year. Failure to attend three (3) meetings in
30 a year may result in a recommendation of removal from the council to the governor or other
31 appropriate appointing authority. A quorum at the meeting shall consist of seven (7) voting
32 members present.

33 **40.1-29-5. Functions.**

34 The functions of the council shall be:

1 (1) To review and evaluate the behavioral health needs and problems in the state and
2 propose such recommendations as are appropriate;

3 (2) To stimulate and seek the development and coordination of all programs relating to
4 behavioral health, including, but not limited to, such areas as care and treatment, prevention,
5 manpower, research and public education;

6 (3) To encourage interdisciplinary approaches to combating, treating and preventing
7 substance ~~abuse~~ use disorders and mental illness, focusing in particular on integrating support
8 systems for behavioral health care;

9 (4) To act as the advisory committee to the department of ~~mental health, retardation,~~
10 behavioral healthcare, developmental disabilities and hospitals and the governor on any funds
11 made available to the department by the federal government for substance ~~abuse~~ use disorders
12 and/or mental health treatment and prevention purposes;

13 (5) To stimulate and investigate research as it affects planning and implementation of
14 behavioral health care systems in the health care environment;

15 (6) To make an annual report to the governor and the general assembly during the month
16 of January, setting forth:

17 (i) The nature and extent of the behavioral health care problems in the state;

18 (ii) Such information and recommendations as the council deems necessary to deal with
19 the problems as documented;

20 (iii) A review of the council's activities during the preceding year, including but not
21 limited to, reports relative to activity, performance and need;

22 (iv) Any plans developed by the council to deal with the behavioral health care problems
23 identified by the council;

24 (v) Other recommendations as may be appropriate and in the public interest.

25 **40.1-29-6. Staff and employees.**

26 The director of ~~mental health, retardation,~~ behavioral healthcare, developmental
27 disabilities and hospitals shall provide the council with such professional and secretarial staff and
28 other support as shall be appropriate for it to carry out its designated functions. The director of the
29 department of children, youth, and families and the director of the ~~department~~ division of elderly
30 affairs shall provide the council with such additional professional and secretarial staff and other
31 employees as shall be appropriate for the council to carry out functions related to the respective
32 responsibilities of these departments. All departments and agencies of the state shall furnish any
33 advice and information, documentary and otherwise, to the council that is deemed necessary to
34 fulfill the purpose and functions of the council.

1 SECTION 2. This act shall take effect upon passage.

LC001327

EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

RELATING TO BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND
HOSPITALS -- GOVERNOR'S COUNCIL ON BEHAVIOR HEALTH

1 This act would increase the membership and change the composition of the governor's
2 council on behavioral health from twenty-six (26) to thirty-one (31) voting members and would
3 make technical amendments to reflect the current names of state departments/divisions/agencies
4 enumerated in the statute.

5 This act would take effect upon passage.

=====
LC001327
=====

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
 - a) Public meetings or hearings? ☒ Yes ☒ No
 - b) Posting of the plan on the web for public comment? ☒ Yes ☒ No
 - c) Other (e.g. public service announcements, print media) ☒ Yes ☒ No

If yes, provide URL:

BHDDH presents to the Governor's Council on the Block Grant at least 3 times each year and works with the steering committee on needs and gaps. The Department presented the combined block grant application at the 8/10/17 meeting of the Governor's Council on Behavioral Healthcare, emailed the draft application to the Council on 7/31/17 and held a conference call on 8/22 from 11:00-12:30 to discuss the application and answer questions and receive comments and posted the draft application to its website: www.bhddh.ri.gov/mh/index.php

Footnotes:



CONNECTING FOR OUTCOMES

2017 – 2018 Strategic Plan

ABSTRACT

Connecting for Outcomes outlines six strategic goals and related strategies that serve as a road map for the Division of Behavioral Healthcare and guide activities implemented with Substance Abuse and Mental Health Block grant funds during the calendar years 2017-2018. These goals are congruent with the U.S. Substance Abuse Mental Health Administration's National Behavioral Health Quality Framework, responsive to behavioral health needs identified, and incorporate strategies or approaches that have been recommended by behavioral health planners throughout the state of Rhode Island.

Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, Division of Behavioral Healthcare

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Executive Summary

Rhode Island spends more on direct and indirect behavioral healthcare than most other states (2015 Truven Health Analytics, Final Report)¹. Behavioral health problems include substance use disorders; alcohol and drug addiction; and serious psychological distress, suicide, and mental disorders. A series of recent needs assessments have identified the following themes with respect to behavioral health in Rhode Island:

- Rhode Island 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
- Rhode Island 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

In order to address these findings, behavioral health services cannot exist in a vacuum. Thus, the theme of our plan is *"Connecting for Outcomes."* We are committed to coordinating and integrating behavioral health services in schools, healthcare and community settings. Connecting our systems and integrating services improves access and offers expanded capacity across the continuum. Additionally, we plan to improve partnerships with systems that provide supporting services that often contribute to poor health such as unstable housing and lack of employment. Many steps are currently underway that illustrate this commitment to connecting for outcomes. For example, the State Innovation Model (SIM) is aligning resources with BHDDH's SBIRT grant to integrate the work of Community Health Teams with screening for substance use disorders and make available the expertise of child psychiatry into pediatric care. Regional Substance Use Prevention Coalitions are aligning with Health Equity Zones around community-based strategic planning and implementation of local strategies. BHDDH is exploring partnerships with the Housing Resource Commission to expand the continuum of housing options to include Recovery Housing, as well as, collaborating with Rhode Island Housing and the Division of Medicaid to increase access to supportive housing (affordable housing coupled with housing retention services) through the implementation of the 811 program, awarded by the US Department of Housing and Urban Development.

There are six overarching goals for the Division of Behavioral Health for the calendar years 2017 and 2018 and these will guide current and future use of Substance Abuse and Mental Health Block Grant funds. These goals are consistent with those of SAMHSA's National Behavioral Health Quality Framework. They are:

¹ Rhode Island Behavioral Health Project: Final Report. Rhode Island Executive Office of Health and Human Services, Department of Health, Department of Behavioral Health, Developmental Disabilities and Hospitals, Office of the Health Insurance Commissioner with Truven Health Analytics, September 15, 2015.
<http://www.eohhs.ri.gov/ReferenceCenter/ResearchAnalysis.aspx>

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

Specific steps in implementing the strategies and the roles of BHDDH/DBH functional units and individual staff are described in detail in ***“Connecting for Outcomes: Implementation and Operational Plan,”*** an internal operational plan.

MISSION, VISION, and VALUES

BHDDH MISSION

The Department's mission is to serve Rhode Islanders who live with mental illness, substance use disorders and developmental disabilities by leading innovations in prevention and quality, directing the continuum of care and guiding resources to promote safe, affordable, integrated services across the health care spectrum.

VISION

To be a leader in the development of innovative, evidence based programs that improve care delivery, strengthen the service delivery network and best serve those who 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.

Core Values -REACH

RESPECT- We strive to interact with all Rhode Islanders in a manner that respects their diversity, needs and experience, with fairness and compassion. We honor the dignity and worth of every individual.

EXCELLENCE- We strive to provide excellent service to *all our customers* in a timely, efficient and professional manner.

ACCOUNTABILITY- We strive for honesty, transparency and value in everything we do and in every service that we render.

CREATIVITY AND INNOVATION- We strive to be a leader and integrate high quality, evidence based, innovative approaches to care delivery that promote health and well-being.

HOPE- We strive to empower *those we serve* by respecting their choices, aspirations and beliefs; encouraging self-determination and helping them achieve improved health, wellness and quality of life.



Division of Behavioral Healthcare Services - Organization 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 with the Executive Office of Health and Human Services for the purposes of determining the Maintenance of Effort for the substance abuse education, prevention and treatment programs as a result of the state consolidating the behavioral health Medicaid funding. All policy, planning and oversight of substance abuse education, prevention and retreatment are under the auspices of BHDDH. The Office of Facilities and Program Standards and Licensure, within the Department, is responsible for the licensing of behavioral health, developmental disabilities and traumatic brain injury programs for the State of Rhode Island.

The Division of Behavioral Healthcare Services (DBH) maintains the overall responsibility for planning, coordinating and administering a comprehensive State-wide system of mental health promotion and substance abuse prevention, intervention and treatment activities. The overarching goals of the Division are to:

- Promote wellness and assure quality treatment and prevention throughout the State with the vision that all Rhode Islanders will have the opportunity to achieve the best possible health, resiliency and recovery and well-being;
- 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 of Behavioral Healthcare is organized into 4 Units:

Policy and 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 will insure that the state's behavioral healthcare service system is responsive to the needs of the consumers, families, allies, advocates and communities we serve and are 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.

For more information go to <http://www.bhddh.ri.gov/>.

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. They are:

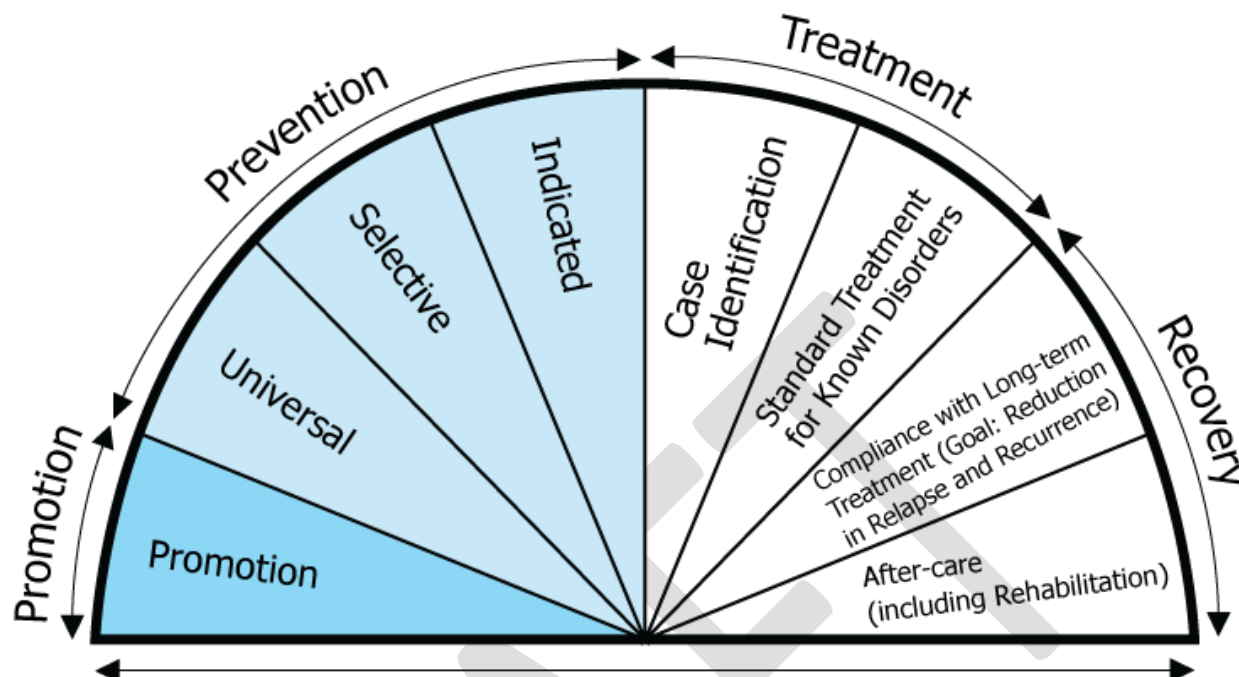
1. Promote the most effective prevention, treatment and recovery practices for behavioral health disorders
2. Assure behavioral healthcare is person, family and community centered
3. Encourage effective coordination within behavioral healthcare and between behavioral healthcare and primary care and other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

The six broad goals contained in this plan are supported by an array of strategies aimed at priority populations and objectives established consistent with SAMHSA's National Outcome Measures (NOMs). The need for expanding the reach of these strategies and the populations with whom they are implemented is undeniable but current funding is insufficient to fully address the need. The Division of Behavioral Healthcare's funding streams for federal fiscal years 2017-2019 reflect priority populations or strategies specifically identified by the funder (SAMSHA) in the Substance Abuse and Mental Health Block Grants and discretionary grants/cooperative agreements awarded to the state. In cases where BHDDH/DBH has selected strategies or priority populations not prescribed or defined by the funder, it based on the efficacy of the strategy or cost burden borne if a population's needs aren't prioritized. Specific steps in implementing the strategies and the roles of BHDDH/DBH functional units and individual staff are described in detail in ***"Connecting for Outcomes: Implementation and Operational Plan,"*** an internal operational plan.

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:
(see Appendix A for service descriptions)

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

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.

According to SAMHSA, recovery services also include 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 Division of Behavioral Healthcare is aligning its strategic planning process with the Substance Abuse and Mental Health Administration's (SAMHSA) key initiatives in order to maximize its impact in Rhode Island and increase the state's competitiveness for funding opportunities. The following are SAMHSA's strategic initiatives many of which have been incorporated into this two year plan:

- Prevention of Substance Abuse and Mental Illness
- Workforce Development
- Health Care and Health System Integration
- Trauma and Justice
- Recovery Supports
- Health Information and Technology

SAMHSA is a major funding source of behavioral health services and programs through the Substance Abuse Prevention and Treatment and Mental Health Block Grants awarded to states and competitive funding made available through Discretionary Grants. To that end, this strategic plan focuses primarily on projects, initiatives and activities funded by the Block Grant.

SAMHSA identifies priority populations to be targeted by Block Grant funds:

- Pregnant women and women with dependent children
- Intravenous drug users
- Tuberculosis services
- Early intervention services for HIV/AIDS
- Primary prevention services
- Children with Serious Emotional Disturbances (SED)
- Adults with Serious Mental Illness (SMI)
- First Episode Psychosis (FEP)

SAMHSA has developed outcome measures to determine performance and improve accountability of prevention and treatment programs. DBH reports data on these measures to SAMHSA. These outcome measures guide deliverables and performance measures that DBH includes in service contracts

particularly those funded by SAMHSA dollars. There are specific measures for Prevention and Treatment programs that are used to indicate the following outcomes:

1. Abstinence from drug/alcohol use
2. Increased/Retained Employment or Return to/Stay in School
3. Decreased Criminal Justice Involvement
4. Increased Stability in Housing
5. Increased Social Supports/ Social Connectedness
6. Increased Access to Services (Service Capacity)
7. Increased Retention in Treatment-Substance Abuse
8. Use of Evidence-Based Practices

A full description of SAMHSA's National Outcome Measures (NOMs) domains, outcomes and measures may be found in Appendix B.

Background

This section summarizes relevant findings from a variety of comprehensive needs assessment addressing behavioral health needs, resources and gaps. In addition, there have also been a number of other plans developed by task forces, committees and workgroups charged with examining consequences and outcomes related to behavioral health. Key findings, proposals and recommendations from this rich body of work are described briefly. Brief synopses, citations and web links, where available, are provided in Appendix C.

Needs Assessment

A number of behavioral health focused needs assessments conducted in the past year have helped to shape priority goals and objectives for 2017-2018 for the Division of Behavioral Healthcare. 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 which are reflected in the goals and objectives contained in the next section.

- 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

The findings of these needs assessments have informed many of the goals, intermediate objectives and strategies that are defined in this strategic plan. Examples of the strategies that are informed by these needs assessments include expansion of peer recovery support services including adding Recovery

Community Centers, increasing rates of retention in treatment, housing stabilization and supported employment.

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) ²- 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; 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 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 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. The network of regional prevention coalitions will implement activities and evidence based practices that are designed to obtain a 10% reduction by 2019 among 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 - 2015³

Rhode Island Governor's Overdose Prevention and Intervention Task Force

² 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

³ Rhode Island's Strategic Plan on Addiction and Overdose: Four Strategies to Alter the Course of an Epidemic. Rhode Island Governor's Overdose Prevention and Intervention Task Force, November 4, 2015.

<http://preventoverdoseri.org/the-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 disposal units throughout the state; 4-5) Increase general 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 abuse 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; to use prescriber, Prescription Drug Monitoring Program (PDMP) and 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 - 2015¹

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.

Goals and Objectives

There are six overarching goals for the Division of Behavioral Healthcare for the calendar years 2017 and 2018. These goals are consistent with those of SAMHSA's National Behavioral Health Quality Framework. Target populations, outcome objectives, intermediate objectives and strategies associated with each goal are described in the tables below. Please note that the populations, outcome and intermediate objectives are limited to those provided by entities that are licensed or funded by BHDDH. **Connecting for Outcomes: Implementation and Operational Plan** an internal operational plan, lays out a detailed set of activities implemented in support of the strategies named here.

Goal 1: EVIDENCE-BASED PRACTICES -Promote the most effective prevention, treatment and recovery practices for behavioral health disorders.					
Priority Populations	Outcome Objectives	Indicators/Measures	Intermediate Objectives	Indicators/Measures	Strategies
1.1 Adults in OP, IOP, Short-Term and Long-Term Residential treatment for SUD	By 2019, increase percent of clients reporting abstinence from drug/alcohol use by 1% from baseline (NOM domain #1) Baseline: ST res alcohol = 82.7% LT res alcohol = 78.5% OP alcohol = 81.5% IOP alcohol = 64.8% ST res drug = 79.1% LT res drug = 77.2% OP drug = 69.7% IOP drug = 58.7%	% of clients abstinent from alcohol at discharge among clients using alcohol at admission Source: TEDS, CY 2015 % of clients abstinent from drugs at discharge among clients using drugs at admission Source: TEDS, CY 2015	By 2019, each SUD provider will adopt a minimum of one new EBP. By 2019, each CMHC will adopt one new EBP or increase fidelity to existing EBPs being implemented.	# staff trained in EBP # clients receiving EBPs	Assess number and types of EBPs currently implemented and adherence to fidelity standards Identify practices across levels of care that address Needs Assessment and BG priority populations i.e. pregnant women and women with children, adolescents, young adults ages 18-25 Work with payers to create payment rates that foster implementation of EBP with fidelity Develop training and technical assistance plan
Adults in IHH and ACT services	By 2019, increase percent of clients reporting improved functioning from 73% to 75%.	% of clients that report improved functioning Source: URS Table 9			

Goal 1: EVIDENCE-BASED PRACTICES -Promote the most effective prevention, treatment and recovery practices for behavioral health disorders.					
1.2 Adults in treatment for SUD and/or mental illness	By 2019, maintain percent of clients reporting stability in housing (NOM domain # 4) Baseline: ST res = 89% LT res = 81.4% OP = 97.9% IOP = 95.5% By 2019, maintain or decrease percent of clients that are homeless or living in shelters at or from 4.9%	% of clients in stable living situation Source: BHOLD or TEDS/BG Table 15 % of clients homeless or living in shelters Source: URS Table 15	By 2018, increase the number of licensed BH providers certified as Housing Stabilization providers from 1 to 7 By 2018, Increase collaboration between ACT and IHH teams with supportive housing providers from 1 to 4	# certified providers # MOUs # clients with housing plans	Provide training and technical assistance on certification process Case conferences between teams Resulting in transition/housing retention plans
1.3 Adults in IHH/ACT	By 2019, decrease number of clients who smoke by 5% over baseline requested 3/20/17	% of clients that smoke Source: IHH Metrics	By 2019, increase the number of individuals referred for smoking cessation services	# individuals referred for smoking cessation	Refer IHH/ACT clients for smoking cessation services
1.4 Adults in treatment for SUD and/or MI	By 2019, increase the number of recovery community centers that are accredited by the Council for the Accreditation of Peer Recovery Support Services (CAPRSS) from 0% to 80%.	# of recovery community centers accredited by CAPRSS at the provisional level or above	By June of 2018, 100% of recovery community centers receiving state or federal funds through BHDDH will submit applications to CAPRSS	# applications submitted to CAPRSS	Include requirement for accreditation in new contracts/re-contracting Use CAPRSS and other technical assistance sources to build CRO capacity to attain accreditation
1.5 Adults in outpatient treatment or recovery from SUD	By 2019, increase the number of houses that are certified according to national standards from 0 to 50.	#of houses that are certified by the local certification body	By 2018, 50 houses will submit application for certification	# applications # trained	Provide outreach and training to recovery home providers

Goal 2: PERSON-CENTERED CARE -Assure behavioral healthcare is person, family and community centered.					
Priority Populations	Outcome Objectives	Outcome Indicators/Measures	Intermediate Objectives	Indicators/Measures	Strategies
2.1 IHH clients ACT clients	By 2019, decrease/maintain percent of clients discharged for non-treatment adherence from 4.65% to 2% (NOM domain #7)	% of IHH/ACT members discharged for non-compliance or who terminate services prior to completion against clinical advice Source: IHH/ACT Metric	By 2018, 100% of CMHCs will Adopt/amend discharge policy to reflect ROSC principles	# provider policy changes # outreach contacts for clients	Review discharge policies to ensure proper focus on risk and proper use of outreach strategies prior to discharge Tie payment to attainment of 2% rate of discharge non-treatment adherence
2.2 IHH clients ACT clients	By 2019, increase percent of clients reporting positive perception of person-centered care from 83.5% to 87%.	% reporting self-directed treatment goals Source: URS table 11 #4	By 2018, adopt a minimum of one policy change in provider practice or organization policy to reflect ROSC principles	# provider level policy changes # trainings on person centered planning	Offer training for clinical teams in ROSC, shared decision making, team management, structure, flexibility and functioning Train providers on tools to implement cultural competence assessments. Consultation with consumer groups and family re: person centered planning. Train the trainer on trauma-informed care

Goal 3: COORDINATED CARE -Encourage effective coordination within behavioral healthcare and between behavioral healthcare and primary care and other health care, recovery and social supports.

Priority Populations	Outcome Objectives	Indicators/Measures	Intermediate Objectives	Indicators/Measures	Strategies
3.1 Adults with or at risk for substance use disorders including adults in the Department of Corrections	By 2019, improve overall health from baseline by 5% among adults screened through SBIRT.	% of clients reporting improved overall health Source: GPRA	By 2018, standardize SBIRT implementation in 10 health settings from	# individuals trained # screened # health sites adopting SBIRT	Offer standardized SBIRT training through RI College School of Social Work Train peer navigators, peer counselors, Community Health Teams
3.2 IHH and ACT clients	By 2019, decrease percentage of adults readmitted to a hospital 30 days after discharge from a prior hospital admission baseline requested 3/20/17 (NOM domain #6)	Percentage of acute inpatient stays that were followed by a readmission within 30 days Source: Claims	By 2018, increase percent of clients receiving a face to face follow up within 3 days of hospital discharge from baseline to target (TBD)	Percentage of IHH/ACT members that have a face to face contact within 3 days of discharge Source: IHH metrics	Conduct follow up face to face contact within 3 days of discharge Develop policies changes to improve care coordination Provide linkages to community based services prior to discharge
3.3 Adults with or at risk for substance use disorders, mental illness and co-occurring disorders.	Increase percentage of clients who report reduced visits to the Emergency department for mental health or substance use issues who have received services from peer recovery specialist. (NOM Domain #5)	Percentage of clients who received emergency department treatment Source: BRSS TACS survey q. 46 & 47.	By 2018, increase the number of peers integrated into clinical teams by 20% By 2018, increase the number of new certified Peer Recovery Specialists (PRS) by 20% By 2018, 30% of certified Peer Recovery Specialists (PRS) will obtain re-certification	# peer trainings # individuals trained # placed in internships # peers certified # peers re-certified	Provide base training for individuals seeking PRS certification Create opportunities for internships in clinical settings Develop specialty training to work with priority Block Grant populations

3.4 People living with human immunodeficiency virus (HIV) (PLWH)	By 2019, increase access to behavioral health care services to PLWH by 20% baseline requested 3/20/17	# of clients with HIV in treatment services Source: BHOLD # of clients with HIV accessing recovery services Source: BRSS TACS survey	By 2018, decrease average wait time for residential beds for PLWH from 21 days to 1 day By 2018, provide point of contact testing to 2,000 OTP HH clients unaware of their HIV status	# of PLWH reporting waiting less than 24 hours # of PLWH using BH services # staff trained on HIV specialization and care coordination	Expand residential bed capacity for PLWH Provide training on care coordination for PLWH
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Goal 4: HEALTHY LIVING FOR COMMUNITIES -Support communities to use best practices to enable healthy living.					
Priority Populations	Outcome Objectives	Indicators/Measures	Intermediate Objectives	Indicators/Measures	Strategies
4.1 Adolescents 12-17 years old	By 2019, reduce prevalence of alcohol use by 3% from 2016 baseline (NOM domain #1) By 2019, reduce prevalence of marijuana use by 3% From 2016 baseline (NOM domain #1) By 2019, reduce the number of adolescents in grades 9-12 who reported feeling sad or hopeless from 26% to 24%.	Past 30 day use of alcohol Source: RI Student Survey Past 30 day use of marijuana Source: RI Student Survey Feeling sad or hopeless Source: YRBS	By 2019, increase the number of school districts implementing Project SUCCESS/ student assistance services from 27 to 30 By 2018, increase the number of in school youth expressing disapproval of use of ATOD by 10% over 2016 base line By June 30, 2018 increase the number of mental health promotion interventions from 0 to 5.	# schools # districts # referrals made # school policy changes Disapproval of use of alcohol, tobacco and other drugs (ATOD) RI Source: Student Survey # strategies proposed Reach of strategies Source: Impact	Develop a funding stream to increase the number of schools implementing Project SUCCESS/student assistance services Regional Prevention Coalitions will implement Mental health promotion activities

					Identify a universal screening for use by Project SUCCESS
4.2 Adolescents 12-17 years old	By 2019, maintain/reduce tobacco sales violation rate at or below 20%	% of tobacco retailers that sell tobacco to minors Source: Synar Survey	By 2019, increase number of compliance checks (added enforcement) over 2018	# compliance checks # individuals trained	Conduct compliance checks of retail outlets Offer vendor training Additional enforcement
4.3 Adults with Opioid Use Disorders	By 2019, reduce opioid and prescription overdose deaths by 1/3, from 290 in 2015 to 159.	# of overdose deaths Source: Medical Examiner, RI DOH	By 2018, increase the percentage of prevention coalitions implementing overdose prevention activities	# individuals trained # individuals exposed to messages # events	Prescriber education/academic detailing RX Take back days
4.4 Adults with SUD	By 2019, increase percentage of clients reporting use of Social Supports by 10% from baseline: (NOM domain # 5)	# of ways peer specialist has helped Source: BRSS TACS #59	By 2018, increase the number of Recovery Community Centers in the state from 2 to 3	# recovery community centers	Fund recovery community centers that utilize best practice approaches and become accredited

Goal 5: REDUCTION IN ADVERSE EVENTS -Make behavioral healthcare safe by reducing harm caused in delivery of care.					
Priority Populations	Outcome Objectives	Indicators/Measures	Intermediate Objectives	Indicators/Measures	Strategies
5.1 IHH and ACT clients	By 2019, decrease percentage of adults in IHH and ACT services hospitalized for suicide attempts baseline requested 3/20/17	Hospital claim in past 6 months Source: claims	By 2018, increase policies that address risk management practices	# of updated treatment plan post incident that reflect good risk management practices	Employ sound assessment processes across all domains Utilize Medication Management (EBP) Increase rehabilitative services offered to IHH & ACT clients

					Screen for co-occurring disorders
Goal 6: AFFORDABLE/ACCESSIBLE CARE -Foster affordable, high quality behavioral health care through a new and recovery-oriented delivery model.					
Priority Populations	Outcome Objectives	Indicators/Measures	Intermediate Objectives	Indicators/Measures	Strategies
6.1 Adults with OUD	By 2019, reduce the number of admissions to hospital Emergency Department overdose related visits from 1,573 to 1,049.	# overdose related Emergency Department visits Source: RI Department of Health	By 2018, increase reach of peer recovery specialists by 10% By 2018, increase use of crisis response services by 25% By 2019 expand the number of new MAT interventions offered by existing providers from 1-3 medications	# of peer encounters # calls to helpline # screened # referred to services # outreach contacts # of individuals trained in MAT (Source GOTF) # of new settings using MAT (Source GOTF) # of MOUs (Source MAT grant)	Deploy Peer Recovery services as a part of crisis response and aftercare Create a crisis response system that includes a physical crisis center, 24 hour helpline, stepdown beds, extended hours, mobile outreach and aftercare Educate EDs to use Buprenorphine and make referrals to Waivered physicians Educate hospitals to offer MAT within inpatient settings and start prior to discharge. Cross institution collaborations between referring and accepting institutions. Increase capacity of existing care providers to providing alternate types of federally approved MAT

Future Goals

Employment First Campaign
Specialize Recovery Housing for SABG populations
Specialized Residential Programs
(MHPRR Right sizing the continuum of care)
Improve data quality

Implementation Plan

DBH will develop a detailed plan to guide the implementation of the strategies listed in this plan. The Implementation Plan will identify specific tasks, the parties responsible, and a time line for completion. The plan will also look at the funding available for each strategy.

Acknowledgements

Governor's Overdose Prevention and Intervention Task Force Action Plan

Acronyms

ACT	Assertive Community Treatment
BHDDH	Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
COE	Center of Excellence
DBH	Division of Behavioral Healthcare
FEP	First Episode Psychosis
HEZ	Health Equity Zone
IHH	Integrated Health Homes
IOP	Intensive Outpatient
MAT	Medication Assisted Treatment
NOMS	National Outcome Measures
OP	Outpatient
RIDOH	Rhode Island Department of Health
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention and Referral to Treatment
SED	Serious Emotional Disturbances
SMI	Serious Mental Illness

Appendix A – Service Descriptions

Prevention Strategies

1. **Information Dissemination:** This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco and drug use, abuse and addiction and their effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, limited contact between the two.

Examples of activities conducted and methods used for this strategy include:

- Media campaigns
- Brochures
- Radio/TV public service announcements
- Speaking engagements
- Health fairs

2. **Prevention Education:** This strategy involves two-way communication and is distinguished from the Information Dissemination strategy by the fact that interaction between educator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision making, refusal skill.

Examples of activities conduction and methods used for this strategy include:

- Classroom and/or small group sessions
- Education programs for youth groups

3. **Alternative Activities:** This strategy provides activities that exclude alcohol, tobacco and other drug use.

An example of an activity conducted and method used for this strategy include:

- Drug free dances and parties – pre prom events - SADD

4. **Community-Based Processes:** This strategy aims to enhance the ability of the community to more effectively provide prevention service. Activities in this strategy include organizing, planning enhancing efficiency and effectiveness of service implementation, interagency collaboration, coalition building and networking.

Examples of activities conducted and methods used for this strategy include:

- Community and volunteer training
- Systematic planning
- Multi-agency coordination and collaboration

5. Environmental Strategies: This strategy establishes or changes written and unwritten community standards, codes and attitudes which will thereby influence incidence and prevalence of the abuse of substances.

Examples of activities conducted and methods used for this strategy include:

- Promoting the establishment of drug use policies in schools
- Assisting communities to maximize local enforcement
- Modifying alcohol and tobacco advertising practices

6. Problem Identification and Referral: This strategy aims at identification of those who have used alcohol or illicit drugs and assessed their behavior.

An example of the activity conducted and method used for this strategy include:

- Student assistance programs

Treatment Services

1. General Outpatient Services - provide an array of services that include but are not limited to individual, group and family counseling, and education. These programs offer comprehensive and coordinated diagnostic, clinical, and educational services that may vary in intensity level according to the needs of the individual served.
2. Integrated Co-occurring Treatment - organizations shall organize their services so that individuals with co-occurring substance abuse and mental health service needs receive treatment in an integrated manner.
3. Medication and Laboratory Services – medications are often an essential component of treatment, helping to maximize the functioning of persons served while reducing targeted symptoms. All medication services must be coordinated with a person's psychosocial interventions and be an integral part of his or her recovery-oriented treatment plan.
4. Case Management Services - provide the supportive assistance an individual needs to attain the goals of his or her behavioral health treatment plan for individuals with substance use disorders and to access medical, social, educational, and other services essential to meeting basic human needs.
5. Community Psychiatric Supportive Treatment - provide goal-oriented and individualized treatment for the persons served through assessment, planning, treatment, support, linkage, advocacy, coordination, and monitoring activities. The intensity and frequency of the service, as well as its location, is based on the individual needs of the person. These services may be provided by individual staff or by teams who, through a supportive relationship(s), promote the individual's recovery.
6. Intensive Outpatient Services - interventions of greater frequency and intensity than General Outpatient or routine Community Support Services that are provided to individuals at risk of a relapse or an escalation of their illness.

7. Community Integration Services - are designed to help persons with behavioral health needs to optimize their personal, social, and vocational competency in order to live successfully in the community. Included are services presently known as Vocational Rehabilitation, Psychosocial Rehabilitation, Supported Employment, Supported Education, and other community-based rehabilitation services.
8. Supported Housing Services - assist individuals and families to obtain and/or maintain affordable, safe housing when they may otherwise have difficulty in doing so.
9. Residential Services - these programs operate twenty-four (24) hours a day, seven (7) days per week providing services and supervision to designated populations. Services promote recovery and empowerment and enable individuals to improve or restore overall functioning.
10. Outpatient Detoxification Services –offer the flexibility of remaining at home during the detoxification period. This level may be appropriate for patients without significant comorbid conditions and who have a support person willing to stay with them and monitor their symptoms.
11. Medical Detoxification Services - Medical Detox in an inpatient setting offers around the clock medical supervision and care by professional staff, and offers availability of treatment for serious complications. These settings offer separation from the substance-using environment. Length of stay is individually determined by medical necessity due to severity/complications of withdrawal symptoms
12. Opioid Treatment Programs - provide medication assisted treatment for individuals with an opioid use disorder. OTPs in RI are licensed by BHDDH to provide Methadone treatment with counseling, behavioral therapies, and case management as well as drug free counseling services.

Appendix B – National Outcome Measures

NOMs' Domains, Outcomes, and Measures, FYs 2011 and 2012 NOM				
	Domain	Outcome	Treatment Measures	Prevention Measures
1	Reduced Morbidity	Abstinence From Drug/Alcohol Use	Clients with no alcohol use at admission versus discharge	30-day use
			Clients with no drug use at admission versus discharge	Perception of risk/harm of use
				Age of first use
				Perception of disapproval/attitudes
2	Employment /Education	Increased/Retained Employment or Return to/Stay in School	Clients employed or in school at admission versus discharge	Perception of workplace policy
				Average daily school attendance rate
3	Crime and Criminal Justice	Decreased Criminal Justice Involvement	Clients without arrests (prior 30 days) at admission versus discharge	Alcohol-related traffic fatalities
				Alcohol- and drug-related arrests
4	Stability in Housing	Increased Stability in Housing	Clients being in stable housing situation at admission versus discharge	Not applicable*
5	Social Connectedness	Increased Social Supports/Social Connectedness	Clients participating in self-help and/or support groups at admission versus discharge	Family communication around drug and alcohol use
6	Access/Capacity	Increased Access to Services (Service Capacity)	Not applicable*	Number of persons served by age, gender, race and ethnicity
7	Retention	Increased Retention in Treatment-Substance Abuse	Length of stay from admission to discharge	Number of evidence-based programs and strategies
				Percentage of youth seeing, reading, watching, or listening to a prevention message
8	Use of Evidence-Based Practices	Use of Evidence-Based Practices	Not applicable*	Number of evidence-based programs and strategies

Appendix C – Recent Behavioral Health Needs Assessment and Plans

Needs Assessments

State Epidemiological Profile (2015)⁴ - Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

Substance Abuse and Mental Health in Rhode Island (2015): A State Epidemiological Profile focused on comparisons of Rhode Island to the nation overall and region on several key behavioral health indicators related to consequences, consumption and risk or protective factors. The State Epi Profile helps to identify how RI compares on some national indicators of behavioral health. (Insert brief description of SEOW and its history).

Key findings included:

- Recent (past month) use of illicit drugs and marijuana are still major concerns among Rhode Islanders of ***all age groups*** especially since prevalence rates exceed the national averages. RI excess is greatest for past month marijuana use followed by past month illicit drug use.
- Drug abuse or dependence remains a concern across ***all age groups***; and needing but not receiving treatment for drug use is of particular concern among adults aged 26 years and older.
- Black ***high school students*** in RI as compared to the US are at a higher risk of ever cocaine use and ever methamphetamine use, while Asian and White ***high school students*** are at a high risk for current marijuana use.
- Substance abuse admissions for heroin from 2012-2014 have dramatically increased. More data are needed to identify the key demographic populations at risk.
- Compared to the US, RI adults aged ***18-25 years*** have a greater unmet need for treatment for DSM-IV alcohol abuse/dependence.
- RI adults aged ***26+ years*** have higher prevalence of serious mental illness in the past year, any mental illness in the past year, and having had at least one major depressive episode in the past year relative to national averages.
- Drug-related overdose deaths are a primary concern for RI. Data collection that can distinguish between prescription drug and street drug overdose is needed to better understand the nature of this problem.

Truven Report 2015-Interagency

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) developed a Request for Proposals to look at the supply, demand

⁴ Rosenthal SR, Buka SL. On behalf of the State Epidemiology and Outcomes Workgroup of Rhode Island and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals. Substance Use and Mental Health in Rhode Island (2015): A State Epidemiological Profile. Cranston, RI: Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, 2016. Retrieved from <http://www.riprc.org/?s=State+Epidemiology+>

and cost of all behavioral healthcare services throughout the state. Truven Health Analytics was selected and reviewed multiple data sets. A Population Health Framework grounded data analysis, interpretation, and subsequent policy recommendations in the knowledge that behavioral health disorders may be preventable developmental conditions and different age groups require different types of interventions and services.

Results of the study indicated that:

- Treatment for children's mental health disorders may not be keeping up with need.
- That potential treatment gap in turn may be affecting adolescents' experiences, including adolescent drug use and the rate of those aged 16–18 years who are not in high school and have not completed high school.
- Supporting family home environments and improving the match between childhood behavioral healthcare needs and treatment are all potential opportunities for Rhode Island.
- Hospitalizations for all adult age groups are too high.

The study also determined that while Rhode Island was spending significant resources on behavioral health care, the dollars were being spent on high end/high cost services such as psychiatric inpatient beds, emergency department visits and psychotropic medications, while community-based interventions were under-resourced. See full citation and web link on page 11.

Community Behavioral Health Clinics Needs Assessment (2016) - Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals received a planning grant from the United States Substance Abuse Mental Health Services Administration to design a system of Certified Community Behavioral Health Clinics. The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals Certified Community Behavioral Health Clinics Needs Assessment by Catchment Area Report (7/15/2016)⁵ utilized a comprehensive approach to look at wide variety of within state indicators of behavioral healthcare needs within eight (8) catchment areas.

BHDDH conducted four focus groups held specifically to gain input for the initiative from consumers of MH and SUD services. The focus groups were conducted at BH agencies familiar to the consumers, to increase their participation and comfort with sharing concerns. BHDDH staff met with 15 leaders from consumer and family member organizations across the state to gain their perspectives on gaps in services, barriers to care and needed enhancements to the system. Finally, there was also a survey administered to a sample of 638 consumers, allies and other key stakeholders to obtain information on their perception of needs, strengths and challenges. The breakdown of respondents is as follows: 33% self-identified as consumers or family members; 42% from mental health or substance use service organizations; 11% from other human service agencies (e.g., DCYF, Juvenile Justices).

⁵ Certified Community Behavioral Health Clinics Needs Assessment by Catchment Area Report, (Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals with DataSparkRI.org, 7/15/2016).

Key findings are as follows:

- 74% reported Crisis Services as Inadequate
- How Could CMHC Services Be More Accessible? Top Five:
 - Offering walk-in appointments
 - Offering services in a different language other than English
 - Providing appointment reminders
 - Offering services for deaf and hard of hearing
 - Offering services for the visually impaired.
- Top Five Locations Outside Community Mental Health Centers Where Should Services Be Provided:
 - Home
 - School
 - Homeless Shelter
 - Domestic Violence Shelter
 - Primary Care Office.
- Other Highlights:
 - Transportation cited as major issue in obtaining services
 - Staffing would be more reflective of the community if more staff were bilingual/bicultural and more ethnically and racially diverse.

State Youth Treatment Planning Grant⁶- Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (unpublished)

BHDDH received a SAMHSA cooperative agreement in 2015 to create a blueprint for a unified, recovery focused service approach for youth ages 12-25 with substance use disorders and/or co-occurring substance use disorders and mental health conditions. This goals of this project include: 1) building and funding an integrated service continuum (screening, referral, assessment and evidence-based interventions and supports) guided by principles and practices that are recovery focused, person-centered, culturally competent, trauma and evidence informed; 2) building the knowledge, skills and abilities of a coordinated, culturally competent, trauma informed, recovery oriented workforce; 3) raising awareness through social marketing to change parental and societal norms that are favorable toward substance use.

A planning retreat was conducted on July 28, 2016 with over forty seven (47) participants in attendance representing youth, young adults, family members, state agencies, and providers. The participants were split into a number of groups. Several themes were recorded among various populations of youth and young adults served by the behavioral health system in RI. These were:

- Increase prevention, early identification and early intervention services among 12-17 year olds

⁶ *Rhode Island State Youth Treatment Planning Grant Planning Retreat*, RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, July 28, 2016.

- Increase coordination of care across school, community, youth serving organizations and state agencies for youth and young adults ages 12-25
- Increase use of age appropriate peers as advocates and peer services for youth and young adults
- Increase parity for youth and young adult behavioral health services (reimbursement rates for credentialed professionals and evidence based or evidence informed practices)

Statewide Health Inventory Utilization and Capacity Study (2015) - Department of Health⁷

The purpose of this study is to comply with the provisions of section 23-93-5(b) of the Rhode Island General Laws, as amended (RIGL), that were established in 2014 by the Rhode Island General Assembly. This study reports the findings from health inventory surveys across 12 areas of the health care system. They include Primary Care, Outpatient Specialty Practices, Behavioral Health, Hospitals, Nursing Facilities, Assisted Living Residences, Adult Day Care Programs, Home Health, MRI Imaging Centers, Ambulatory Surgery Centers, and Dialysis Centers. The report includes findings from a Patient and Community survey which was conducted to understand access to care from the perspective of community members. The surveys were further grouped into five sections: Outpatient Care; Hospitals; Long-Term Care; Facilities and Centers; and Patients and Community.

Based on these findings, RIDOH recommends exploring focused efforts around recruitment and retention of primary care physicians. In addition, RIDOH recommends uniform data collection of race, ethnicity, and languages of patients, as well as identification of strategies to address cost barriers that prevent patients from receiving needed care in a timely fashion. RIDOH also recommends adopting strategies to improve access to community-based living arrangements, such as assisted living residences. Development of such strategies aligns with the “Reinventing Medicaid” initiative.

Conclusions specific to behavioral health were as follows:

- There is limited integration between primary care and behavioral health. Using the same EMR for behavioral health and primary care providers as an indicator of integration, no integration was reported by 75.0%, 89.1%, and 100% of licensed behavioral health clinics, psychology practices, and psychiatry practices, respectively (outpatient care).

Recommendations that specifically addressed behavioral health issues included:

- Increase behavioral health parity through improving access to care for Medicare and Medicaid patients among psychiatry and psychology services (outpatient care)
- Encourage increased integration between primary care and behavioral health to improve patient access and outcomes (outpatient care).

Health Equity Zone Needs Assessment (2016) - Department of Health (unpublished)

Health Equity Zones are geographic areas designed to achieve [health equity](#) by eliminating health disparities using place-based (where you live) strategies to promote healthy communities. [Healthy](#)

⁷ 2015 *Statewide Health Inventory Utilization and Capacity Study*, RI Department of Health, 2015. <http://www.health.ri.gov/data/healthinventory/>

[communities](#) are places where people live, work, play, and learn. These are neighborhoods consisting of social and physical environments that support healthy choices and safe living.

The Centers for Disease Control and Prevention and the Rhode Island Department of Health are collaborating with 10 Health Equity Zones (HEZs) throughout Rhode Island to support innovative approaches to prevent chronic diseases, improve birth outcomes, and improve the social and environmental conditions of neighborhoods across five counties statewide.

Each Health Equity Zone (HEZ) organization's work plan will be implemented over a three or four year period that began in 2015. All HEZs grantees conducted community needs assessments in year one. HEZ work plans, based on the needs identified and prioritized in year one, focus on the residents in neighborhoods that each Health Equity Zone serves. The HEZ work plans present ideas and approaches to invest in local communities and improve population health. Community engagement is a priority in reaching these public health goals.⁸

The HEZ year 1 needs assessment contained 136 items across seven (7) categories including access to healthy foods, physical activity, general health and well-being, social determinants substance use, behavioral health, and, children and families. Among the top issues identified by the ten HEZ sites related to either substance use or behavioral were:

- Need to address growing substance abuse problem (4 of 10)
- Need to address high rates of mental illness and trauma (3 of 10)
- Access to treatment and support for substance abuse (3 of 10)
- Need to address high rates of accidental drug overdose (3 of 10)

Strategic Plans

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

This plan is to outline's BHDDH's primary 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. BHDDH utilizes a life span approach across the continuum focusing on priority populations and activities, including but not limited to substance abuse prevention, mental health promotion, violence prevention and smoking cessation to promote mental wellness in Rhode Island (RI). BHDDH implements a population health model by integrating prevention and mental health promotion across behavioral health systems. The plan reflects on-going efforts to use data and key stakeholder and community participation to set goals and objectives; prioritize evidence-based programs, practices, and policies; coordinate activities; determine key data indicators and evaluation

⁸ Retrieved from: <http://www.health.ri.gov/projects/healthequityzones/> (9/22/2016)

plans to measure outcomes; identify target populations to improve health equity and reduce disparities related to substance use and mental illness; and plan for the sustainability of infrastructures and activities. The aim of this plan is to provide a roadmap to:

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

The plan lays out consequence, consumption and risk or protective targets for primary prevention strategies based comparison to US averages or troubling trends.

Consequence targets (4):

- 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
- Suicide attempts among adolescents

Consumption pattern targets (3-4% reduction in rates by 2019 to bring RI at or below national averages):

- Marijuana use by adolescents ages 12-17
- Use of illicit drugs other than marijuana ages 12-25
- Underage drinking ages 12-20
- Youth use of tobacco or tobacco related products specifically use of electronic nicotine delivery systems

Risk and protective factor targets (10% reduction from baseline by 2019 for priority substance identified among population targeted)

- Perception of risk or harm
- Reduced 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)

See full citation and web link on page 10.

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

This plan released in November of 2015 included four strategic priorities informed by national and local research and published best practices, and are: 1) Establish statewide overdose surveillance mechanisms; 2) Increase access to naloxone training and distribution programs; 3) Implement and expand disposal units throughout the state; 4-5) Increase general public awareness of drug overdose as a preventable public health problem and support and affirm people who are risk of overdose; and, 6) Increase access to substance abuse treatment

The Strategic Plan identifies four key strategies and related activities designed to reduce overdose deaths by one-third within three years, using the key strategies and associated metrics described below:

Treatment Strategy: Every Door is the Right One

The core of this initiative recommends the development of a system of medication-assisted treatment at every location where opioid users are found, primarily: the medical system (Emergency Departments, hospitals, clinics, etc.), the criminal justice system, drug treatment programs, and in the community.

Impact Metric (Monthly): Number of patients with opioid use disorder, number receiving medication-assisted treatment (MAT) per year, retention in medication-assisted treatment, medication utilized.

Rescue Strategy: Naloxone as Standard of Care

This initiative seeks to ensure a sustainable source of naloxone for community and first responder distribution, and a high coverage of naloxone among populations at risk of overdose. *Impact Metric (Monthly):* Number of prescribers prescribing naloxone; Number of naloxone prescriptions dispensed (overall), and to patients filling Schedule II opioid prescriptions or to patients filling opioid and benzodiazepine prescriptions.

Prevention Strategy: Safer Prescribing and Dispensing

The main focus of this strategy is to use prescriber, Prescription Drug Monitoring Program (PDMP) and system-level efforts to reduce co-prescription of benzodiazepines with opioids (for pain or opioid use disorder). *Impact Metric (Monthly):* Number of benzodiazepines and opioid prescriptions dispensed within 30 days for same patient; number of opioid treatment program patients also receiving prescribed benzodiazepine.

Recovery Strategy: Expand Recovery Supports

This initiative recommends the large-scale expansion of recovery coach reach and capacity. *Impact Metric (monthly):* Number of peer recovery coach encounters to Emergency Department, to hospital, to prison, in street outreach sessions; Rate of referral and retention (one-month) to treatment, to medication-assisted treatment, to recovery supports.

Additional recommendations from Rhode Island's Strategic Plan on Addiction and Overdose include: creation of a dashboard of available data will be created from multiple sources, including the key metrics across all four critical initiatives; a communications plan aimed at supporting each of the initiatives, with specific target audiences, messages, and measurable outcomes; and engagement of Substance Abuse Prevention Task Forces in very community should be engaged to provide greatly needed stigma-reducing programming, supports (especially for families dealing with addiction and loss), and awareness among parents and communities related to help-seeking, overdose awareness, and safer prescribing initiatives. See full citation and web link on page 11.

Highlights of Governor Raimondo's Overdose Prevention and Intervention Task Force

- August 2015: Just months after taking office, Governor Raimondo recognized the overdose and opioid crisis in Rhode Island, quickly **established a comprehensive task force** and gave them a clear mission: Save lives.
- December 2015: The task force submitted a [strategic plan](#) to the Governor and laid out four complementary strategies (Prevention, Rescue, Treatment and Recovery) that seek to cut the number of overdose deaths by one-third in the next three years
- January 2016:
 - Just weeks into the legislative session, Raimondo **signed legislation extending Good Samaritan laws** to remove barriers to calling emergency services in overdose situations
 - Dr. Elinore McCance-Katz, working with the Department of Health, held a **DATA-Waiver Training** session for 125 providers
- February 2016:
 - At her **State of the State address**, the Governor announced her goal to cut the number of overdose deaths by 1/3 in 3 years (Elise Reynolds, who lost two sons to overdose, attended as the Governor's invited guest)
 - Announced **State purchase of naloxone** with Google settlement funds (press event with State Police)
- March 2016:
 - **The Goldners shared their personal story** at the monthly Task Force meeting
 - Announced RIDOH/Baltimore Department of Health partnership to promote **black box warning label** about the concurrent use of opioids and benzodiazepines (Dr. Alexander-Scott participated in local/national press briefing conference call)
- April 2016:
 - **Governor met with families of overdose victims** at Anchor recovery (closed press)
 - **National Prescription Drug Takeback Day** (Governor, Dr. Alexander-Scott attended and spoke at Providence Walgreens event on Elmwood Ave)
 - Dr. James McDonald gave a **Prescription Drug Monitoring Program (PDMP) presentation** to about 200 physicians
- May 2016:
 - Governor released the [Rhode Island Overdose Prevention and Intervention Task Force Action Plan](#) with specific actions and metrics tailored to track progress on the recommendations offered in the Task Force's strategic plan.
 - RIDOH issued a press release highlighting changes in **trends of prescription/illicit drug overdose deaths** and **spike in fentanyl-related deaths**
 - Developed, disseminated **flyer for ambulances** encouraging EMTs to call ahead for recovery coach when responding to overdoses
 - Developed, disseminated **wallet cards for active drug users** that include fentanyl messaging and overdose risk information
 - Dr. James McDonald led a course for **Continuing Medical Education (CME) for health professionals on benzodiazepines**
 - Dr. James McDonald presented to the **South County Health Board/Medical Staff Retreat** on substance use and the role of providers in prevention and treatment

- June 2016
 - With Governor Raimondo's strong support, the **General Assembly passed an ambitious package of bills aimed at addressing the State's overdose crisis**, which Raimondo signed into law
 - The Governor participated in an on-the-record **White House press call** with Michael Botticelli, Director of National Drug Control Policy, Senator Jeanne Shaheen, and Representative Annie Kuster to discuss the urgent need for Congress to act on the President's request for \$1.1 billion to address the prescription opioid abuse and heroin use crisis, and new state-by-state breakdowns of that funding request
 - RIDOH and BHDDH launched a [public awareness campaign](#), featuring testimonials of Rhode Islanders in recovery; the awareness campaign also featured a **new warm line staffed by addiction and recovery specialists**, to help people connect with treatment and recovery services
 - RIDOH and BHDDH launched the [preventoverdoseRI website and public dashboard](#), which provides information on prevention, treatment, and recovery resources and includes publicly available data related to RI's overdose crisis, as well as transparent metrics on progress towards reaching the goals articulated in the action plan
 - The Governor and Dr. Alexander-Scott **met with primary care providers** to discuss expanding access to buprenorphine
 - The Governor and Dr. James McDonald participated in the **International Opioid Conference**
 - Director Elizabeth Roberts of OHHS participated in the **Choosing Wisely** event and spoke about the Overdose Action Plan
 - Dr. Elinore McCance-Katz participated in a **PBS panel on the opioid epidemic**
- July 2016
 - The Governor hosted a **ceremonial bill signing** at Bridgemark Addiction Recovery Services to mark passage of the ambitious package of overdose legislation
 - **CDC came for a site visit** in RI to learn more about innovative strategies in action plan and how they can be replicated elsewhere in the region and country
 - **White House National Drug Control Policy Director Michael Botticelli visited Rhode Island** to learn more about the Anchor ED program and to tour the Gloria McDonald Women's Facility at the ACI to learn more about RI's leadership in **kicking off a pilot medication-assisted treatment program in the state prisons**
 - Dr. James McDonald presented at the **grand rounds at Women & Infants Hospital** on opioid prescribing, controlled substance regulations, the Governor's action plan and the need for suboxone prescribers (over 100 healthcare providers in attendance)
 - Director Boss participated in the **New England Opioid Epidemic Convening**
- August 2016
 - RIDOH and BHDDH signed a memorandum of agreement with the Rhode Island Medical Society and American Medical Association to develop a **state-specific toolkit for healthcare providers** to support safe opioid prescribing; RI was one of only two states chosen by AMA for the pilot
- September 2016
 - Certified Rhode Island's first **Center of Excellence**
 - RIDOH reached **100% enrollment in PDMP**
 - RIDOH issued **press release on fentanyl-related overdose deaths**
 - Directors Alexander-Scott and Boss participated in **Rally for Recovery** event

- **National Heroin and Opioid Awareness Week press event** organized by the U.S. Attorney's Office
 - RIDOH held **data waiver training CME** for healthcare providers
 - RIDOH distributed **relapse planning/discharge tool** to all Emergency Departments
- October 2016
 - RIDOH distributed **brochures** about how to recognize an overdose, how to use naloxone, and how to find recovery services (to pharmacists, provider offices, and CBOs)
 - **NGA conference** held in Rhode Island to help other states learn from Rhode Island's model approach for responding to the opioid crisis
 - Kaiser Health News story on use of **peer recovery coach model** in RI
 - Distributed **hospital relapse planning tools** to hospitals and nurses.
- November 2016
 - SBIRT **grant awards announced by SAMHSA**; BHDDH flagged for reporters
 - Dr. Clarke and 3 inmates from the ACI spoke at the November Task Force meeting
- December 2016:
 - RIDOH shared **news of underreporting of overdose death data** in 2015 and 2016
- January 2017:
 - **Progress report** for Task Force Strategic Plan shared at January Task Force meeting
 - Deborah Parente, the mother of a fatal overdose victim, attended **Governor's State of the State address** as one of the Governor's invited guests
 - RIDOH hired a new overdose communications coordinator
- February 2017:
 - Announced that North Providence and East Providence are **expanding police access to naloxone**; new legislation in effect requiring insurance coverage of naloxone.
 - Task Force meeting held at the ACI to **highlight treatment/recovery initiatives in the state prisons**
 - Launched **Prevent Overdose RI Twitter** account
- March 2017:
 - Released [Levels of Care for Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder](#), a **first-in-the-nation set of statewide guidelines** to save lives by ensuring consistent, comprehensive care for opioid use disorder in emergency and hospital settings
 - Governor Raimondo interviewed by HBO filmmakers as part of outreach efforts for new **national overdose documentary**
 - Announced that **the Recovery Support Line is open 24/7**
 - Held a press conference on **increases in drug overdoses in the Kent Hospital area, identified through the 48-hour reporting system**
 - Amended the state's [Acute Pain Management Regulations](#) to limit initial prescriptions for acute pain, making the prescribing of opioids more judicious and safe; RIDOH sent a [letter](#) to **over 7,000 Rhode Island prescribers as well as other health professionals** about the new regulations
 - Rhode Island Department of Health **mini-grants for drug overdose** were awarded to [nine qualified community-based organizations](#) that supported projects addressing the opioid overdose epidemic.
- April 2017
 - [Instructions for Managing Pain after Dental Surgery](#) without opioids were developed and shared with all licensed Rhode Island dentists

- All licensed physicians, physician assistants, advanced practice registered nurses, dentists, and dispensers received letters from their respective Board representatives about the updated acute pain management regulations, encouraging compliance
- All Rhode Island Emergency Departments (EDs) were sent posters to be placed in high-visibility areas to [educate ED patients on the risks of taking opioids](#)
- The **Surveillance, Response, Intervention (SRI) Work Group** was established with RIDOH, BHDDH, and the Rhode Island Fusion Center to rapidly evaluate and analyze overdose data to determine when and where a public health intervention is needed
- **Drug Take-Back Day** took place on April 29, 2017, with events taking place throughout the state.
- The Rhode Island Department of Health and the Rhode Island Board of Medical Licensure and Discipline announced a partnership with the Warren Alpert School of Medicine formally approving a **curriculum on comprehensive addiction medicine/psychiatry** qualifying Brown medical students for the waiver necessary to prescribe FDA-approved opioids on Schedules III, IV, and V for the treatment of opioid use disorder.
- RIDOH issued a [press release](#) on the updated acute pain management regulations in Rhode Island
- January - April 2017 RIDOH met with facility medical directors and staff at all Rhode Island hospitals about the **48-hour Overdose Reporting Enforcement Plan**.
- Quarter 1 2017 overdose data was shared during Governor's Task Force meeting.
- May 2017
 - RIDOH began sending **48-hour reporting data** to ED medical directors (including data on naloxone distribution, peer recovery coach activity, and onsite counseling services)
 - Rhode Island **Multidisciplinary Review of Drug Overdose Death Evaluation (MODE) Team** issued a [Spring 2017 data report](#)
 - **West Warwick launched its pre-arrest diversion pilot program** in collaboration with The Providence Center
 - RIDOH and Brown University's Medical School offered two **Continuing Medical Education opportunities for providers about how to appropriately prescribe opioids** and consider interdisciplinary approaches to treating patients with pain to support the implementation of the updated regulations for prescribers.
- June 2017
 - Began sending [public health advisories](#) to stakeholders and established the Regional Overdose Action Area Response (ROAAR) regions, based on increases in overdose activity
 - Created [FAQs](#) on the updated Acute Pain Management Regulations for prescribers and dispensers
 - A **Provider Advisory** was sent from the Director of Health to over 7,000 Rhode Island prescribers regarding the U.S. Food and Drug Administration's removal of Opana ER from the market.
- July 2017
 - RIDOH sent a **new [patient education tool](#) on the risks of opioid pain medications** to prescribers and dispensers
 - Distributed **point-of-sale educational materials** for people who have been prescribed opioids

- Governor Gina M. Raimondo **released an [Executive Order](#) with new specific actions to fight the opioid overdose epidemic.** The order will expand access to treatment and naloxone, create pre-arrest diversion programs, develop new prevention strategies targeting families and youth, and establish a Family Task Force to help guide Task Force efforts.
- Rhode Island Department of Health Academic Center and Brown University's Medical School offered **free online CME courses** on how to appropriately prescribe opioids and consider interdisciplinary approaches to treating patients with pain.
- Rhode Island Department of Health **mini-grants for drug overdose prevention were awarded to five qualified community-based organizations** that supported projects addressing the opioid overdose epidemic.
- Rhode Island insurance companies and pharmacy benefit managers (PBMs) **implement a reinforcement mechanism at pharmacies** to help ensure compliance of the updated acute pain management regulations for initial prescriptions.
- Certified Community Care Alliance and Care New England as new Rhode Island Centers of Excellence
- Designated CharterCARE's Our Lady of Fatima and Roger Williams Medical Center as Level of Care 1 Emergency Departments/hospitals for treating overdose and opioid use disorder.
- The Governor **announced a partnership with CVS Health to establish a new Opioid Center of Excellence** focused on medication assisted treatment and outpatient services in Woonsocket, Rhode Island.
- The Governor **signed three bills aimed at combatting Rhode Island's overdose crisis.** The first is a [legislation](#) that enables the disclosure of information contained in prescription drug monitoring databases to a limited number of qualified law enforcement agencies for drug diversion investigations; a [bill](#) that expands the type of pharmaceuticals which may be prescribed using electronic prescriptions while ensuring patient privacy; and, [legislation](#) requiring health care professionals to discuss the risks of addiction with their patients or parent and guardians of patients when issuing opioid prescriptions.
- August 2017
 - Quarter 2 2017 overdose data shared at Governor's Task Force meeting
 - [Prescriber education infographic](#) about the risks of co-prescribing benzodiazepines and opioids disseminated to 7,000 Rhode Island healthcare providers.



Overdose Legislative Report

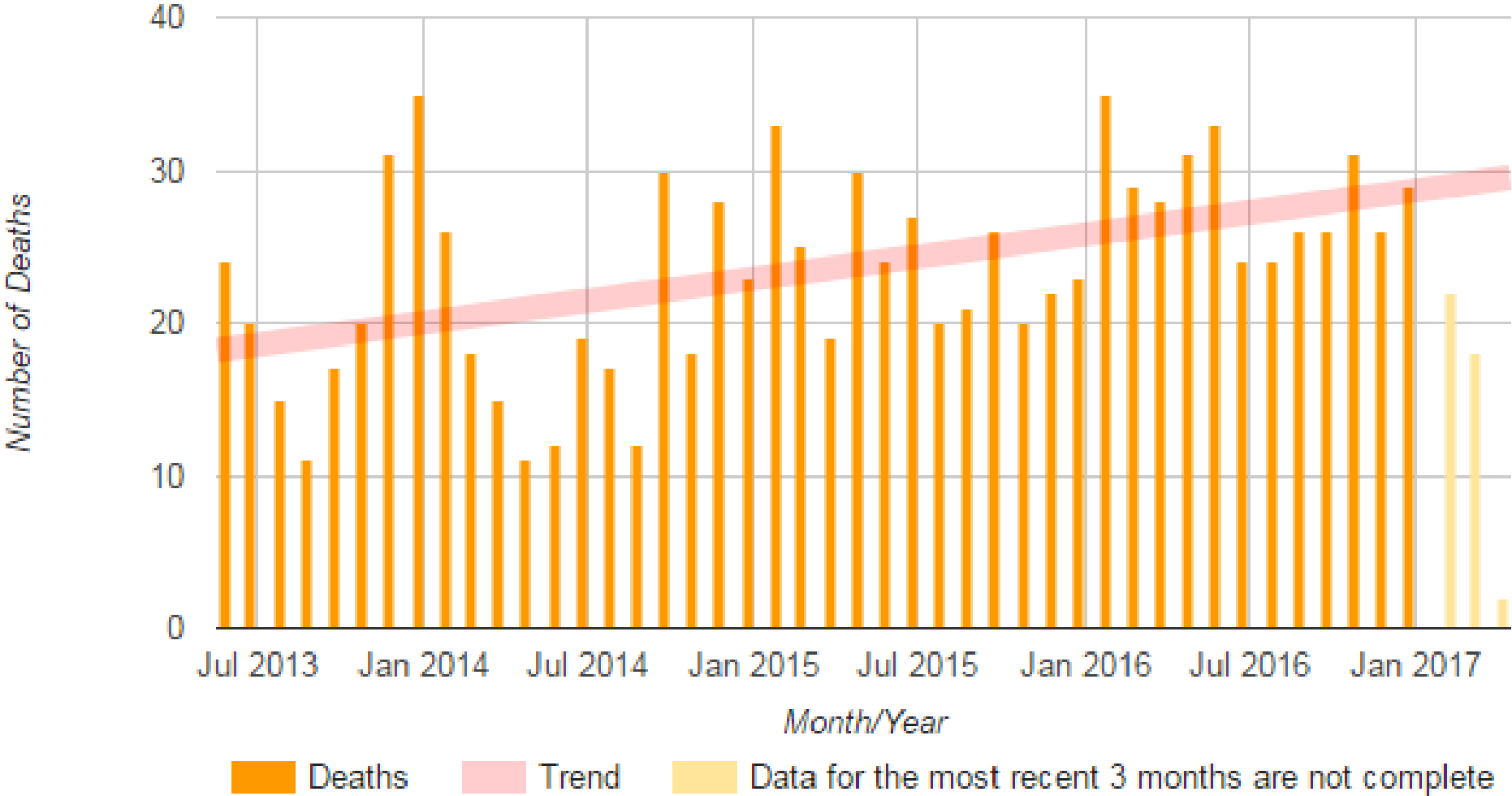
June 2017

RHODE ISLAND DEPARTMENT OF HEALTH

RHODE ISLAND DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES, AND HOSPITALS

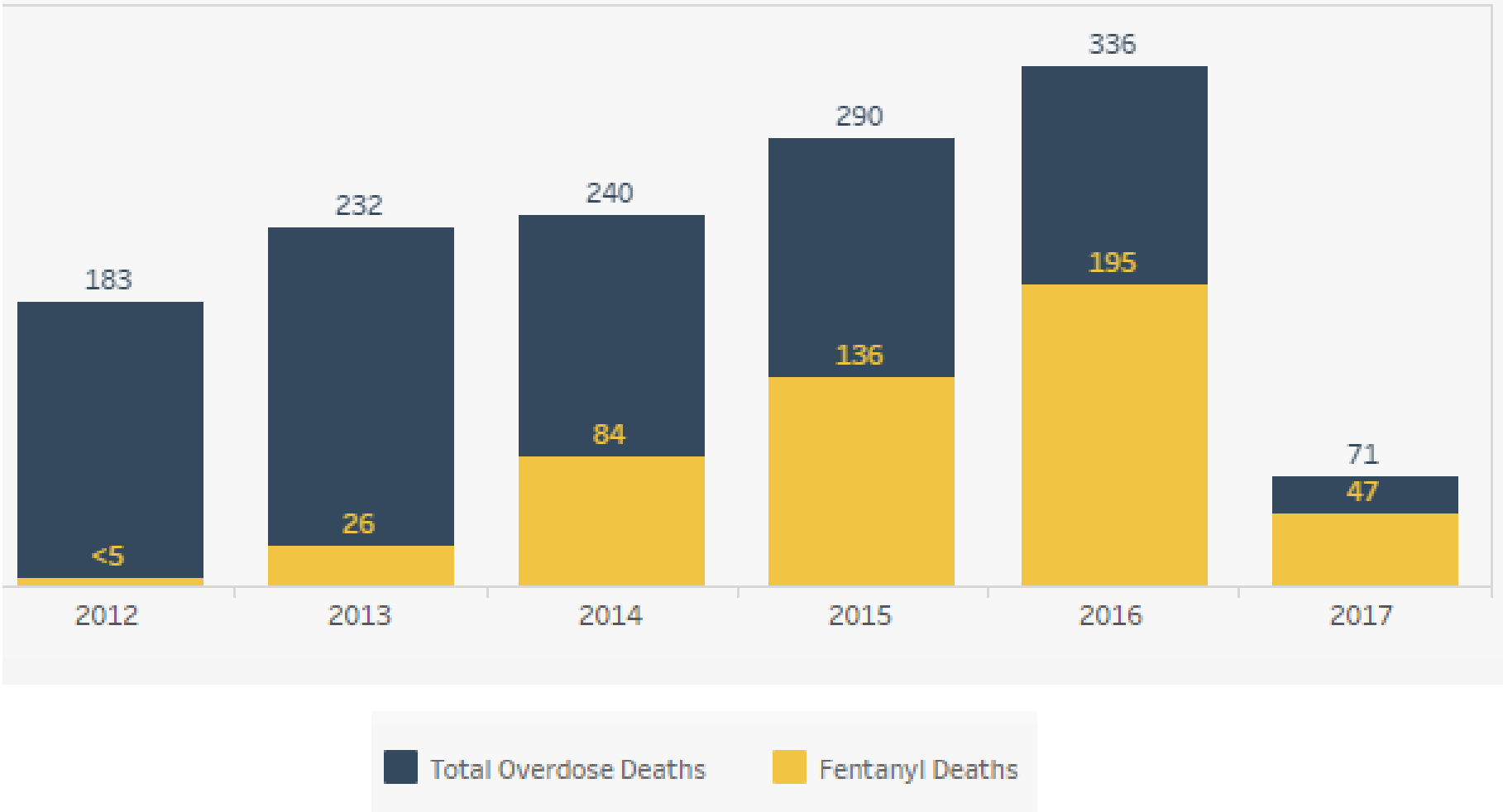


Monthly Accidental Drug Overdose Deaths in Rhode Island





Overdose Deaths due to Fentanyl in Rhode Island





Focus Area 1: Prevention (PDMP)

- As of June 2016, 100% of prescribers are enrolled in the PDMP.
- A customized prescriber profile was mailed to the top 500 prescribers in December 31, 2016. An updated version was developed and is being mailed to the 100 prescribers that received academic detailing intervention (see slides 5&6).
- The RIDOH academic detailer provided in person education and training to the top 100 prescribers as of December 31, 2016. She will visit the top 101-200 prescribers by August 31, 2017.
- RIDOH is piloting integration of the PMDP with an Electronic Health Records (Lifespan) and a Pharmacy Operating System (CVS) in hopes of increasing utilization. Both systems will be integrated in fall 2017.
- RIDOH implemented PDMP auto alerts in January 2017 that notify prescribers when a patient has been to 5+ prescribers and 5+ pharmacies during a 6 month period, has a MME over 90 MME/day, or has overlapping prescriptions for both an opioid and benzodiazepine.



Prescription Drug Monitoring Program (PDMP) Prescriber Profile

Prescriber Name:

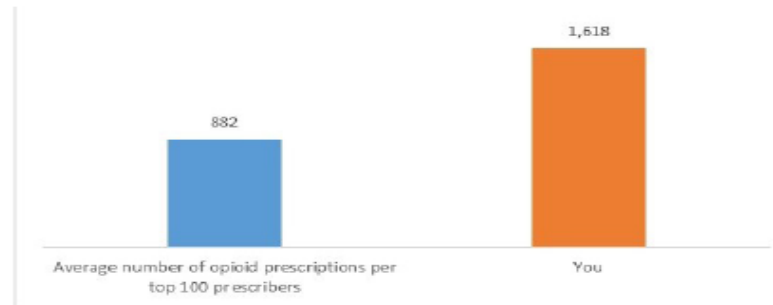
Specialty: **Advanced Practice Registered Nurse**

DEA Number:

Licensing Number: **APRN**

You are in the top **5%** of prescribers of opioids in Rhode Island.

November 2015- May 2016



362 of your patients received an opioid prescription*

8 patient reports were run in the PDMP

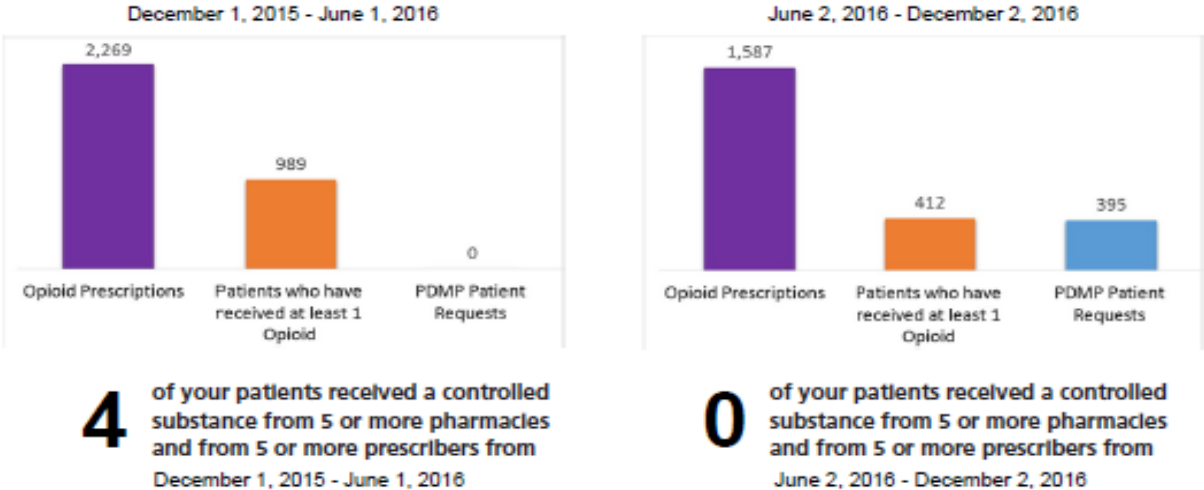
0 of your patients received a controlled substance from
5 or more pharmacies and/or from
5 or more prescribers in 6 months.*

Check the PDMP! www.health.ri.gov/pdmp



Prescription Drug Monitoring Program (PDMP) Prescriber Profile Update

Prescriber Name: **John Doe MD**
Specialty: **Internal Medicine**
Licensing Number: **MD12345**



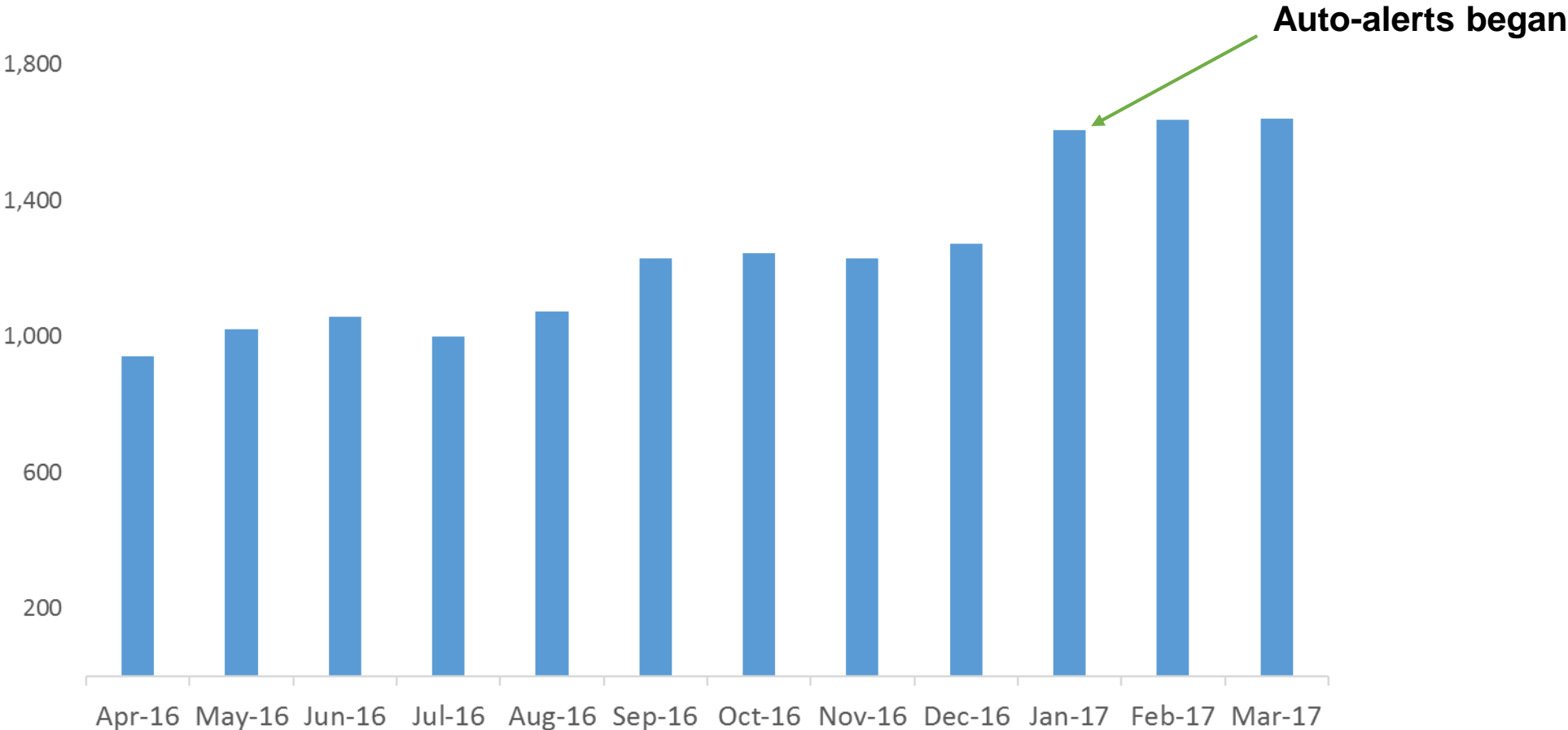
Check the PDMP: www.health.ri.gov/pdmp

NOTE: *Tramadol, a Schedule IV opioid, is included in this data.
*Buprenorphine prescriptions are excluded from the data.



Unique prescribers using PDMP

April 2016 to March 2017



2018 Goal = 3,000 prescribers/month



Focus Area 1: Prevention

Safer prescribing

- RIDOH passed [acute pain regulations](#) in February 2017 that limit initial opioid prescriptions to 30 MMEs per day for a maximum of 20 doses, require prescribers to review the PDMP before initiating an opioid, and require all prescribers of schedule II opioids to complete eight hours of Continuing Medical Education (CME).
- Insurers with RIDOH, BHDDH, and OHIC have developed an [enforcement mechanism](#); it will be effective July 1, 2017.

Education

- RIDOH partnered with BHDDH to offer an enduring eight-hour CME on the Interdisciplinary Treatment of Pain in May 2017.
- RIDOH developed and disseminated a “Prescribing Regulations at a Glance” card and mailed to 5,000 prescribers.
- RIDOH developed and disseminated posters for Emergency Departments to post for patient education on the new prescribing regulations.
- RIDOH Primary Care Physician Advisory Committee with OHIC has convened physicians, insurers, and



Focus Area 2: Treatment

- The Department of Corrections is providing Medication Assisted Treatment (MAT) and no longer stopping treatment in newly incarcerated.
- SAMSHA MAT grant awarded to BHDDH to support startup costs for 2 Centers of Excellence (COE) clinics per year for 3 years. Project Coordinator was hired in March 2017
- CODAC, INC and Eleanor Slater Hospital (ESH) were approved to be the first COEs. Two other providers have submitted for COE certification and will be approved by June 1st.
- CODAC began admitting patients in November: Currently have 68 patients; total since open is 118 patients.
- The COE at ESH will be operated by CODAC and services will start on May 30.
- RIDOH and BHDDH released the nation's first statewide standards for treating overdose and opioid use in hospitals and emergency settings in March 2017. All emergency departments and hospitals in Rhode Island are required to meet the criteria for Level 3 facilities. Charter Care submitted the first application in May 2017.



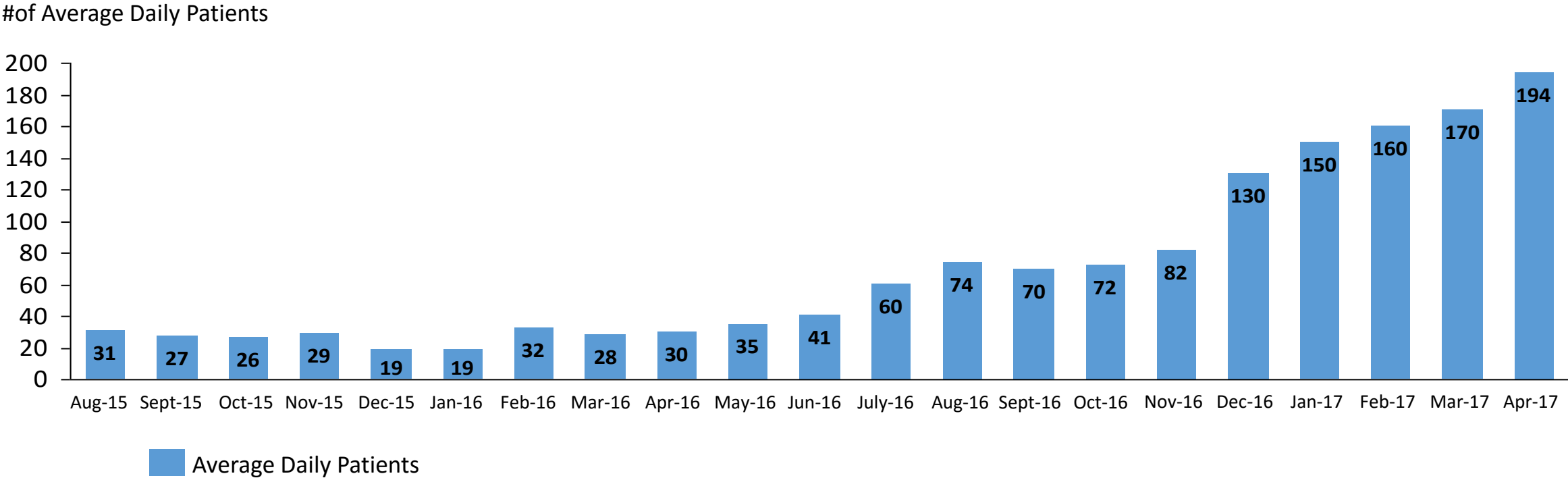
Focus Area 2: Treatment

- Dr. McCance-Katz led progress with the Warren Alpert Medical School to be the first state in the nation to incorporate DATA Waiver training into the medical school curriculum. She received national recognition through NEJM submission; the Medical Board approved standard operating procedure for implementation.
- RIDOH and BHDDH continue to provide tailored technical assistance and capacity building to RI's primary care practice groups to expand buprenorphine and overcome barriers.
- The Brown University Internal Medicine residency is setting up a system to educate all residents on prescribing buprenorphine as a result of our work with primary care leaders.
- BHDDH and RIDOH have trained 308 providers in providing medication-assisted treatment as of April 2017.
- BHDDH has received a SAMHSA STR grant to embed 5 Nurse Care Managers in health settings in 5 high risk communities to increase MAT, to hire 2 psychiatrist at Eleanor Slater to enhance services to patients in Opioid Treatment Programs, and provide three data-waiver trainings for nurses and physicians assistants who can now prescribe buprenorphine.
- RIDOH contracted with The Providence Center to embed a full time social worker into the West Warwick Police Department to provide training on substance use disorder and help officers connect consumers to treatment services in lieu of arrest. This is a pilot project and will be evaluated to determine value of replicating statewide.



Medication-Assisted Treatment at the ACI

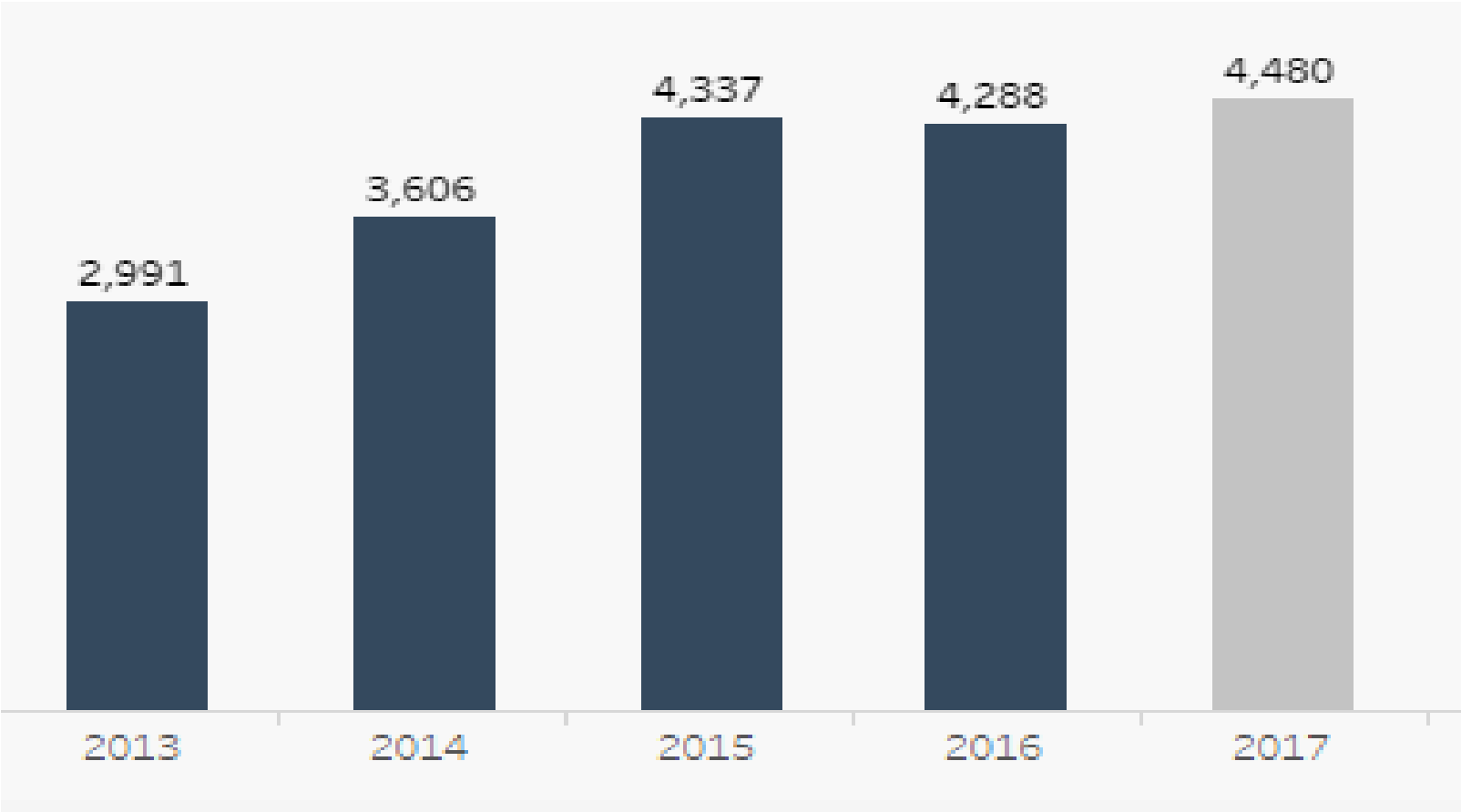
Number of average daily patients by month



This graph shows the average daily patients by month for opioid treatments within the ACI. The funding was awarded in May 2016. Starting in July 2016, treatments included both methadone and buprenorphine. Heavily influencing factors are medication frequency and length of stay in the ACI.



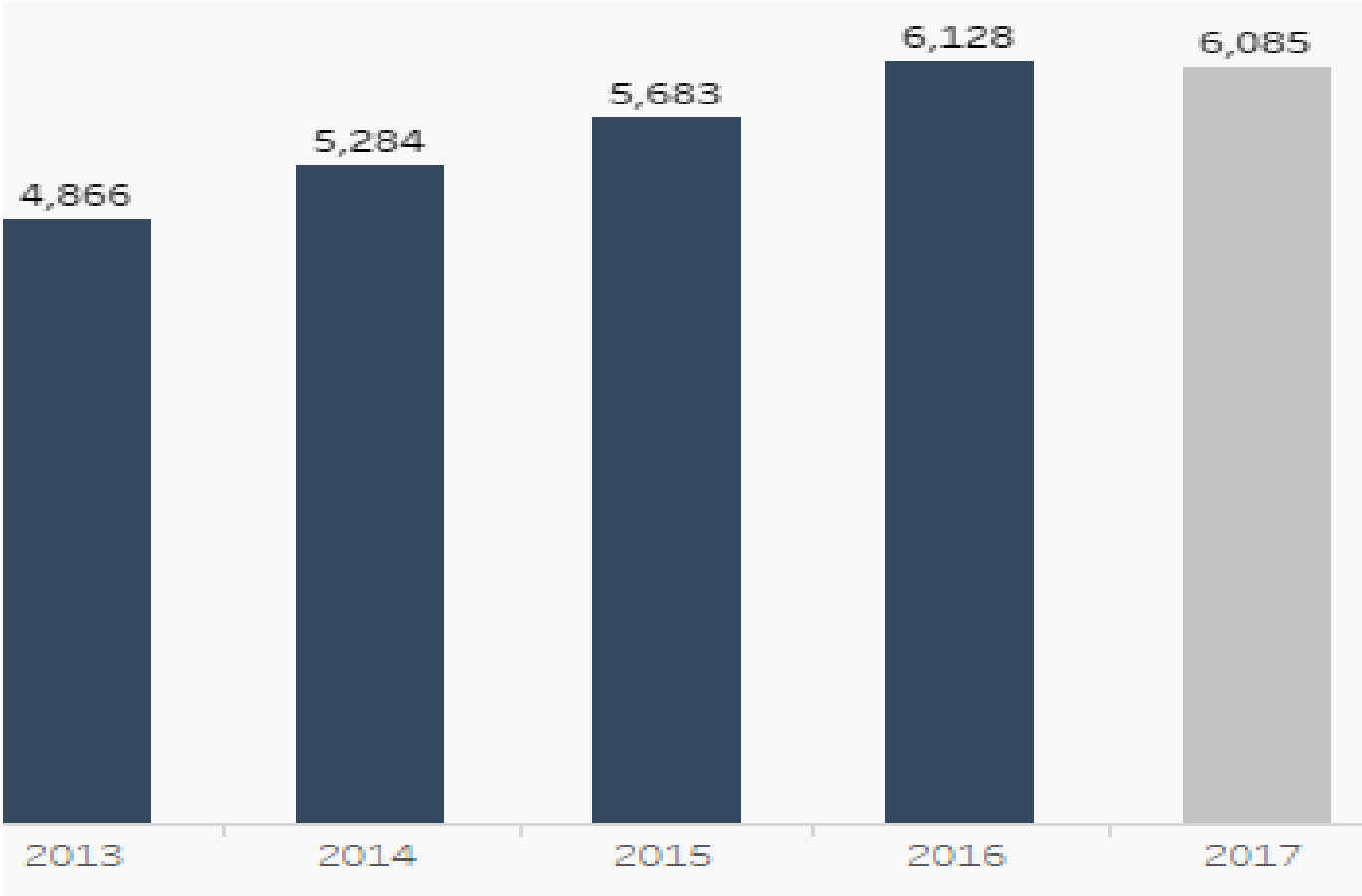
Number of patients receiving buprenorphine (monthly average)



2018 Goal = 6,500 patients/month



Number of patients prescribed methadone (annually)



2018 Goal = 6,152 patients/year

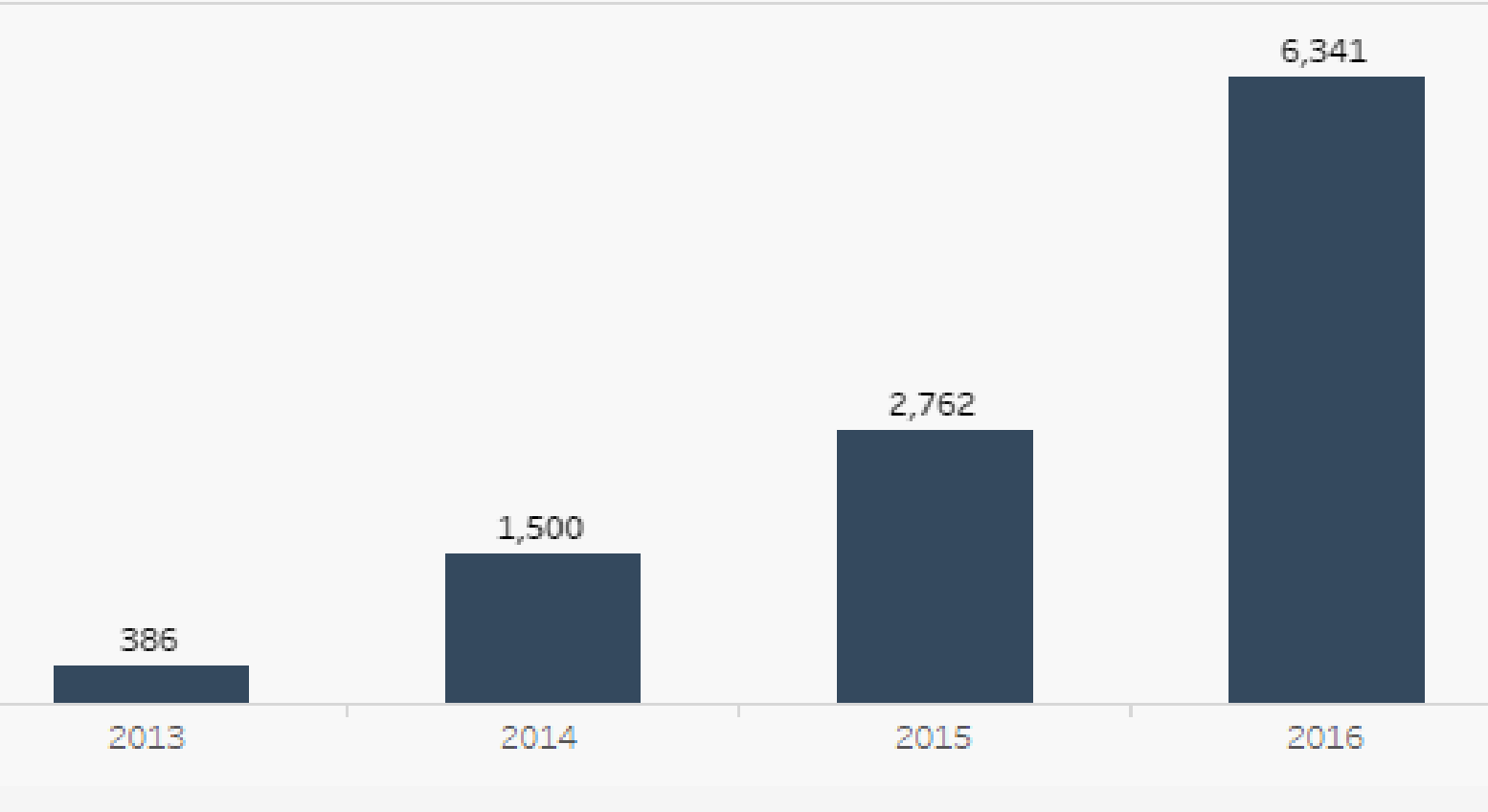


Focus Area 3: Rescue

- RIDOH has a contract with the Medical Reserve Corp. to provide statewide naloxone training, data collection, and technical assistance on distribution.
- All police departments except one (Bristol) are now equipped with naloxone.
- BHDDH secured \$140,000/year for two years from RIDOH and SAMHSA for naloxone distribution to vulnerable populations including inmates upon discharge from DOC and through targeted street outreach by peer recovery coaches.
- Dr. Alexander-Scott has done broad outreach to the Rhode Island physician community to strongly encourage the co-prescription of naloxone (with opioids).
- Dr. Alexander-Scott has sent communications to Rhode Island pharmacists urging them to stock naloxone.
- RIDOH developed and distributed naloxone posters to all pharmacies in Rhode Island encouraging patients to ask their pharmacist about naloxone.



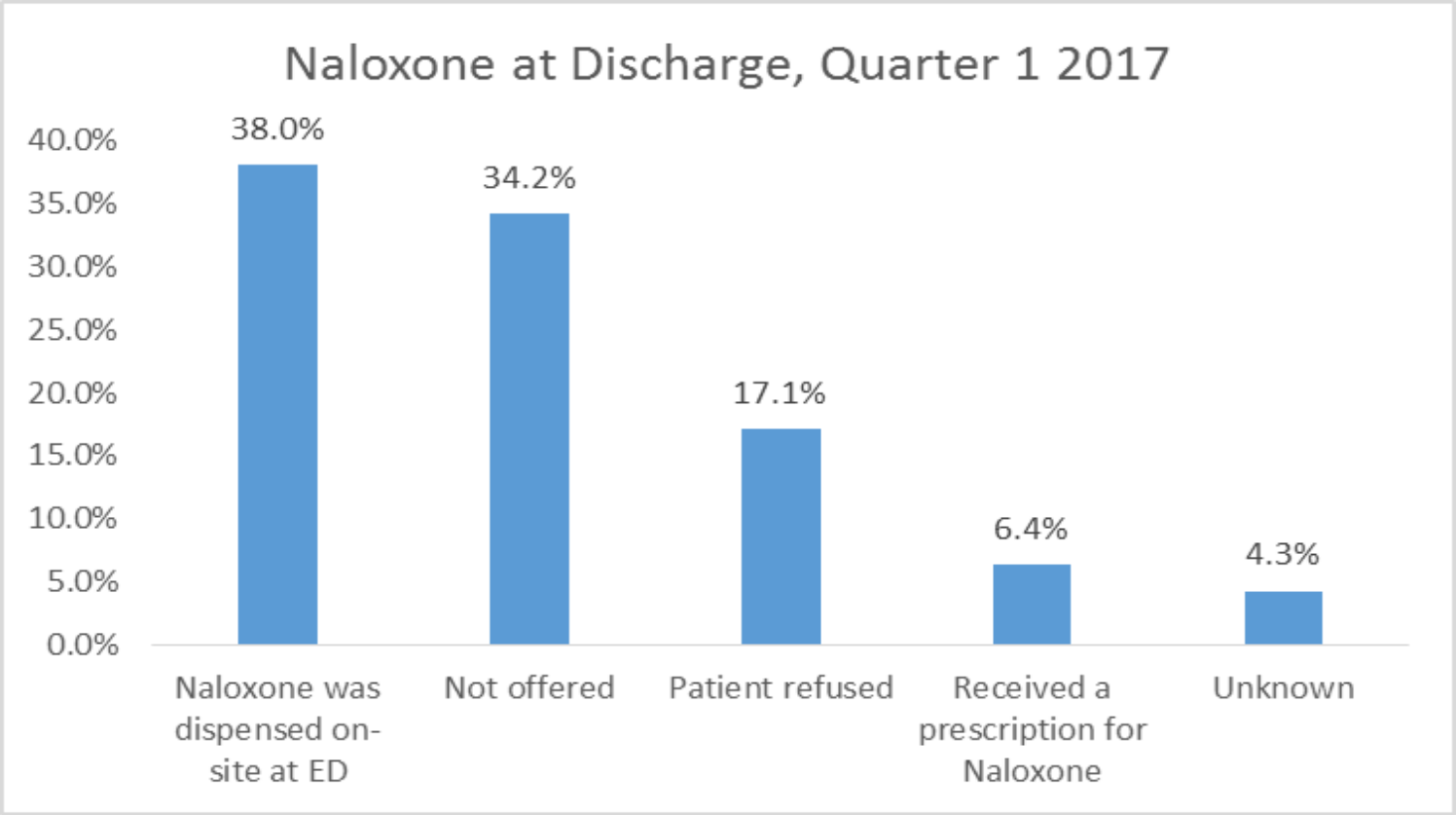
Naloxone Distribution by Year



2018 Goal = 10,000 kits/year



Naloxone Distribution to Overdose Patients in the Emergency Department



Goal = 100 % of overdose patients are offered naloxone



Focus Area 4: Recovery

- BHDDH contracted providers have trained over 300 peer recovery specialists.
- Eight Peers have received specialty training to work at local birthing hospital to assist MAT pregnant mothers and their families.
- While in the Emergency Department, 1,619 individuals agreed to accept a meeting with a peer recovery specialist from AnchorED (through March 2017). **Do not know timeframe**
- A certification plan for all recovery residences receiving any state funding has been developed and RICARES, a peer run advocacy program has agreed to monitor all of the recovery residency for compliance and adherence to the new enhanced training requirements.



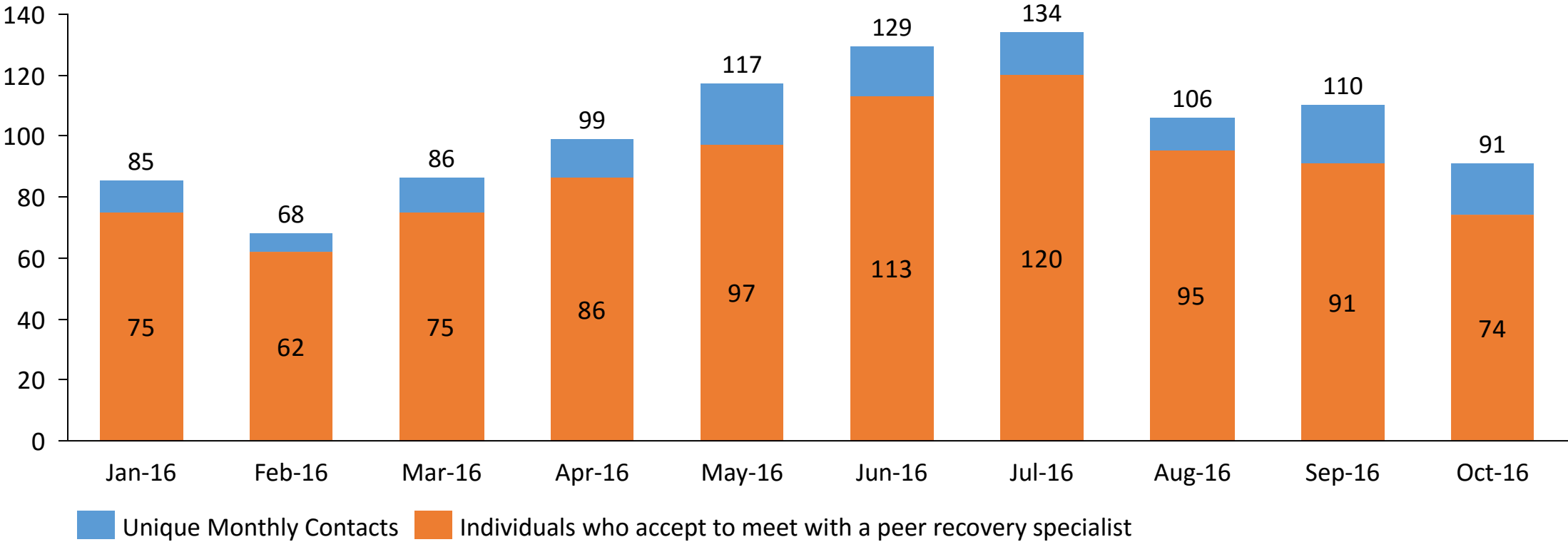
Focus Area 4: Recovery

- BHDDH expects to announce a contract with a new recovery center located in Southern RI by summer 2017.
- RIDOH has a \$110,000/year contract with Anchor Recovery through 2019 to provide peer recovery coaches to inmates upon release from the Department of Corrections and through targeted street outreach to state hotspots.
- BHDDH has received a SAMHSA STR grant to establish 40 Recovery Housing beds with MAT trained staff and administration costs
- In June RIDOH relaunched the “Addiction is a Disease, Recovery is Possible” public media campaign with \$100,000 in federal funding.



Peer recovery contacts in Anchor ED **Need update**

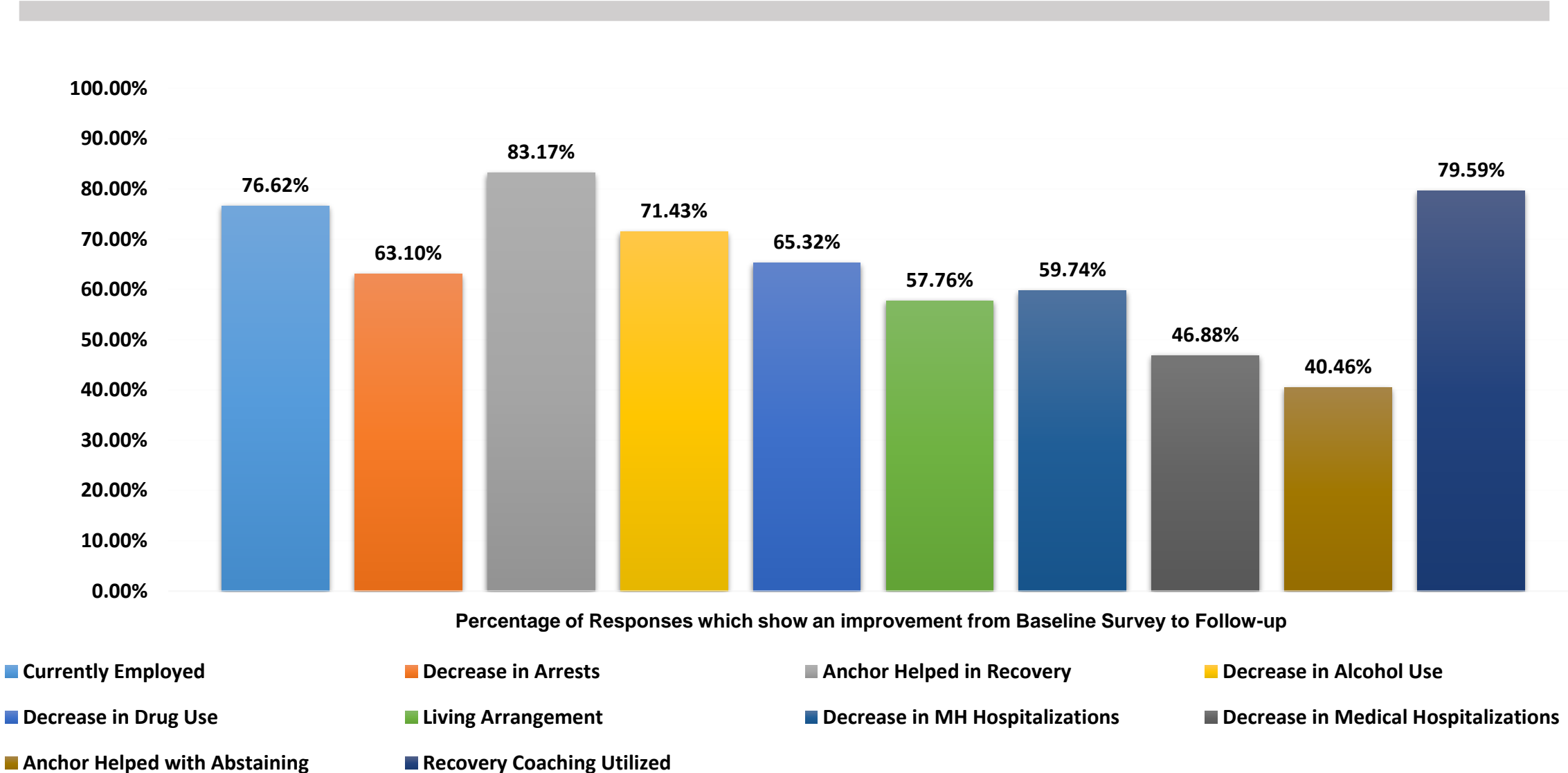
Unique monthly contacts and number of individuals who accept to meet with a recovery specialist in the ED



This graph displays the monthly number of individuals from ANCHOR ED who accept treatment and agree to meet with a recovery specialist in the ED. Note that this is not limited to individuals who accept treatment for opioid use disorder (i.e., it includes treatment for other substances, such as alcohol)



Baseline surveys from individuals being assisted by Peer Coaches **Need update & do not know timeframe**





Data and Surveillance

- RIDOH partnered with Brown University to launch the Drug Overdose Dashboard in June 2016: www.PreventOverdoseRI.org. The dashboard has received national recognition. Data on the site tracks progress on the four strategies and is updated regularly. The website receives over 1,000 unique visitors every month.
- RIDOH received a \$256,000 grant for 3 three years for Enhanced Opioid Overdose Surveillance. A Project Manager/Epidemiologist was hired in January 2017. The project will improve prevention and response efforts by providing more timely data on fatal and nonfatal opioid overdoses including the following datasets: EMS, Medical Examiner data, and Emergency Department data.
- RIDOH convened the first meeting of the Drug Overdose Death Review Team in November 2017. The multidisciplinary group meets on a quarterly basis and reviews a selection of overdose deaths to identify key points of intervention and prevention. A data brief is published after each meeting. Mini grants (\$5,000 or less) are made available to community based organizations to implement 'rapid response' projects that are driven by the data brief findings. The first round of nine mini-grants were awarded in April 2017.
- The RIDOH Lab received \$500,000 in Google Money to purchase a piece of equipment that will decrease the amount of time it takes for the Medical Examiner's Office to confirm a drug overdose death.



2017 Legislative Session – Preventing Overdoses **Remove all Legislative slides?**

Advancing Policy Improvements for the Governor's OD Task Force

Add Naloxone to the Prescription Drug Monitoring Program (PDMP)

- Supports expanding access to naloxone
- Required PDMP reporting is the one cost-effective, comprehensive method to track pharmacy dispensing of naloxone
- Helps to de-stigmatize naloxone, increase co-prescription and improve public health surveillance

Require E-Prescribing for Scheduled Drugs

- Insures prescription integrity
- Reduces opportunities for drug diversion
- Eliminates illegibility as a source of medical errors
- Reduces data entry errors in the PDMP



2017 Legislative Session – Preventing Overdoses

Policy Improvements under Consideration

1. Convene RI Multidisciplinary Review of Drug Overdose Death (MODE) Team

- Multi-agency effort of RIDOH, BHDDH, DOC to include external stakeholders (i.e. healthcare providers, treatment, recovery, public safety)
- Purpose is to identify trends and points for demographic, geographic, or structural prevention efforts
- Overdose epidemic is evolving; adequate response requires thorough investigation
- Expert team will share data, review cases, and publish data brief
- Follows the Child Death Review Team Model; supported by CDC grant



2017 Legislative Session – Preventing Overdoses

2. BHDDH Proposal on Alternative Therapies: Insurers need to cover these therapies with the same copay requirement that patients pay their doctors for an outpatient visit.

- For physicians to reduce prescribing controlled substances for pain management, alternative therapies for pain must be a viable option.
- Right now, patients can't afford referrals to physical therapy, acupuncture or other effective alternative therapies because the copay is far higher, or the therapy is not covered at all, and many people lack the resources to pay out-of-pocket.
- In a [call to action](#) to the nation's physicians by the American Medical Association to [“Help Prevent Opioid Misuse”](#) in February 2016, a national physician survey identified removing barriers to care and recommending alternative treatments as critical components in reducing opioid misuse.
- On the federal level, [H.R. 6](#), the 21st Century Cures Act, will create the Council for 21st Century Cures (Subtitle H--Sec. 1141), a nonprofit corporation, established to accelerate the discovery, development, and delivery of innovative cures, treatments, and preventive measures.