Rhode Island

UNIFORM APPLICATION
FY 2022/2023 Combined MHBG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 09/30/2021 12.01.42 PM)

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 2022

End Year 2023

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 Disabilties 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 Richard

Last Name Charest

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

Email Address richard.charest@bhddh.ri.gov

State CMHS DUNS Number

Number 111415381

Expiration Date

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

Agency Name Rhode Island Department of Behavioral Healthcare, Developmental Disabilties 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 Richard

Last Name Charest

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

Mailing Address	14 Harrington Road
City	Cranston
Zip Code	02920
Telephone	401-462-0917
Fax	
Email Address	richard.charest@bhddh.ri.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

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

From	
To	

V. Date Submitted

Submission Date	9/1/2021 6:30:55 PM
Revision Date	9/1/2021 6:31:10 PM

VI. Contact Person Responsible for Application Submission

First Name	Candace
Last Name	Rodgers
Telephone	401-462-1829
Fax	
Email Address	candace.rodgers@bhddh.ri.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2022

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**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
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Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
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Section 1935	Core Data Set	**42 USC § 300x-35**
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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

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 Clean 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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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

Daniel J. McKee
Governor

July 1, 2021

Ms. Wendy Pang
Mr. Yan Rong
Grants Management Specialists
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857

Dear Ms. Pang and Mr. Rong:

I am writing to notify you that Richard Charest, director of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, is authorized as my designee to sign any required documents related to the Projects for Assistance in Transition from Homelessness (PATH) grant, and the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants (including the annual Synar report) for the tenure of my term as Governor of the State of Rhode Island.

Sincerely,

Daniel J. McKee
Governor of Rhode Island

I. State Information

Chief Executive Officer's Funding Agreements, Assurances Non-Construction Programs and Certifications (Form 3)
Fiscal Year 2020/21

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
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Section	Title	Chapter
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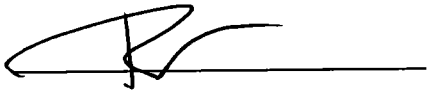
State: Rhode Island

Name of Chief Executive Officer (CEO) or Designee: RICHARD CHAREST

Signature of CEO or Designee[1]: 

Title: DIRECTOR Date Signed: 5/1/21
mm/dd/yyyy

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

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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.
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
7. 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.
8. 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 eall interests in real property acquired for project purposes regardless of Federal participation in purchases.

9. 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.

10. 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 sub agreements.

11. 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.

12. 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 Costal 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).

13. 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.

14. 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.).

15. 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.

16. 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.

17. 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.

18. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

19. 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.

State: *Rhode Island*
Grant: *Substance Abuse Prevention & Treatment Block Grant (SA Block Grant)*
Project: *Supplemental COVID-19 Funding*
Project Period: *9/1/2021-9/30/2025*
Total Allowable Budget: *$**6,150,916***

1. Identify the needs and gaps of your state's SUD services continuum, related to developing a comprehensive prevention, intervention, treatment, and recovery support services continuum.

The needs of Rhode Island's SUD service continuum include:

- Prevention: The lack of statewide implementation of Student Assistance Services, which covers a minimum of three CSAP strategies including education, problem identification and referral, and information dissemination. The fear has been that implementation of this program is lacking in some of the highest need areas of the state still due to funding limitations. We hope to address that with these funds while in turn meeting the required 20% set aside for primary prevention services. The regional prevention task forces continue to support all six CSAP strategies, with strong success around environmental strategies, alternative events, information dissemination, and community-based process continuing throughout the COVID-19 pandemic. Through PFS funding, additional efforts are placed on environmental and education strategies in 20 high-need communities.

- Intervention: A high need in our state system (and of primary focus through these supplemental funds) is around mobile crisis infrastructure. In the last proposal, Rhode Island proposed a Crisis Assistance Helping Out on the Streets (CAHOOTS) pilot to start this work. Additional funds will be requested to support this model and consideration of other models for statewide implementation to address the need and gap in system infrastructure. In alignment with this mobile crisis issue, a need for Crisis Intervention Training for first responders also was outlined. We added it to the proposal for the first COVID-19 supplemental dollars under our Mental Health Block grant but for the second supplement, we left it out as a discretionary grant for early diversion is working on statewide implementation of this training for first responders, including police officers. Outreach has also been identified as an issue, as we currently employ outreach teams through our state's PATH grant but due to funding limitations, they cannot work directly with client who do not have at least one mental health-related diagnosis. To reduce duplication of services, it makes sense to fund the same teams already in these communities to continue serving all homeless individuals regardless of diagnosis and expand the program.

- Treatment: It's been noted by membership of our state's Governor's Council on Behavioral Health that alcohol use disorder has not gotten the same attention as opioid use disorder in years past. Also, needs were expressed around the importance of providing SUD services in different settings such as jails, shelters, emergency departments, and federally qualified health centers, to name a few. Maintenance in treatment programs, especially medication assisted treatment, is also documented as a need.

- Recovery: Increasing the number of certified peer recovery specialists in Rhode Island. The goal of the Governor's Overdose Task Force is 200 trained and certified peers for the state. Another need is to strengthen the state's recovery community centers outreach, education, and

coordination efforts including naloxone and fentanyl test strip distribution. Another need is to support people with lived experience who lead peer-support organizations to receive the education and support they need to self-sustain. Furthermore, we wish to support more individuals with lived experience to increase their resilience so that the recovery community can continue to strengthen.

- Needs Across the Continuum: Understanding how to consider racial and ethnic equity in implementing all programs from prevention through recovery is a high need, and a current gap in our system. Barriers to SUD services recently identified (or reiterated) through this year's Combined SAPT/CMHS Block grant activities include stigma, transportation, not knowing how to access services, the cost of services, services offered at inconvenient times, racial and ethnic differences, and not providing services in a trauma responsive way. Transportation and housing are two very large issues that we're still trying to find ways to address. With housing not being the purpose of this Block grant, we sought other funding sources to continue our recovery housing program.

2. Describe how your state's spending plan proposal will address the state's substance use disorder services continuum, including a budget that addresses the needs and gaps related to this continuum.

Please see the budget breakdown below to answer this question.

3. Describe your state's progress in addressing the rising drug overdose rate in many parts of the country, and what steps the state will be taking to improve access to SUD treatment, by improving identification of persons in need, reducing barriers to admission to treatment, and strengthening mechanisms to promote client engagement and retention in SUD treatment and recovery support services.

Rhode Island saw a reduction in drug overdose until November 2019 and continued to climb through COVID-19 pandemic. As services began opening again in the winter of 2020, we did see a slight decline in overdose deaths but we're still above the average we were pre-pandemic. BHDDH is funding outreach teams through our state's health department with State Opioid Response (SOR) grant supplement in addition to the outreach service expansion proposed below as part of the PATH extension to cover individuals experience homelessness that have a substance use disorder diagnosis. The funding of a naloxone hub would also help centralize naloxone distribution to reduce waste and overlap while providing education and resources around the use of naloxone and fentanyl test strips. To help streamline the assessment process, we're also working on the development of an ASAM assessment tool that should improve identification of persons in need in addition to the correct level of care for them based on the ASAM criteria. One need that didn't make the cut for funding was piloting a contingency management program. Despite it not being currently in the plan, if other items come in under budget, the hope is to revise the plan to include this pilot for the sake of assisting clients in adhering to their treatment plans, specifically around medication-assisted treatment programs. It was a priority identified by SUD provider and Brown University alike and would fit well with promoting client engagement and retention.

4. Describe your state's progress in implementing the increased and widespread use of FDA approved medications for the treatment of opioid use disorder, alcohol use disorder, and tobacco use disorder, in combination with other substance use disorder evidence-based

treatments and practices.

Overall, the number of individuals receiving medication-assisted treatment has been increasing steadily over the past few years. According to PreventOverdoseRI.org, buprenorphine has increased from 4,355 individuals at the beginning of calendar year 2017 to 5,588 individuals in the beginning of calendar year 2021. Methadone has also been on rise from 5,293 individuals in the beginning of calendar year 2017 to 6,078 individuals in the beginning of calendar year 2021. Buprenorphine treatment capacity has more than doubled in Rhode Island since 2016, as the number of trained and data-waivered medical professionals has steadily risen. However, the number of providers offering Vivitrol (extended release naltrexone) is lower. Naltrexone can be provided through the following treatment providers: Codac Behavioral Healthcare, Inc., Meadows Edge Recovery Center, East Coast Medical, Medical Assisted Recovery, Inc., and the Journey to Hope, Health and Healing. Nicotine replacement therapy is encouraged during the assessment process at substance use disorder providers if a client indicates they use tobacco, and additional work has been done around the creation and implementation of this protocol, and additional Tobacco Treatment Specialist training and training-of-trainers, in the last two years.

5. Explain how your state plans to collaborate with other departments or agencies to address the SUD services continuum.

BHDDH frequently partners with the state's department of health and state's department of corrections on programs related to substance use disorder. In the budget below, you'll see a transportation initiative with the department of corrections to help individuals who have left the corrections system get around to their SUD treatment appointments and initiate or continue participation in the SUD recovery activities. We will continue to co-chair the Governor's Overdose Task Force with the department of health, which is where the genesis of the naloxone hub concept began. We also will work with the Executive Office on Health and Human Services on strategic planning for race and equity across the SUD services continuum.

6. Describe how the state plans to use SABG ARPA funding to promote health equity among identified underserved populations, and how it plans to address health disparities in the planning, delivery, and evaluation of SUD prevention, intervention, treatment, and recovery support services.

To help answer this question, the budget below breaks down a series of investments around race and equity across the continuum of care. In particular, the work towards developing an actionable strategic plan specific to race equity is very important to our state. The statewide implementation of student assistance services in all middle and high schools is needed to address possible disparities due to socioeconomic status. The Imani Breakthrough Project is focused on addressing equity issues and stigma in the faith-based community. If, upon completion of the strategic planning process, programmatic needs are identified, the state will move forward to address those needs with any underspent funds on this supplement to help maximize the impact of this funding on increasing health equity for Rhode Islanders across the SUD service continuum.

7. Describe the state's efforts and plans to promote an increased emphasis on the development, delivery, and support of widespread SUD recovery support services, systems, and mechanisms across the state.

In Rhode Island, there are several recovery related initiatives to create a statewide service of recovery supports. First, through the State Opioid Response (SOR) grant and other dollars through the state, we're able to offer recovery housing to individuals who need a substance-free environment to live while in recovery. The state pays for this on a sliding scale over the course of one year, at which point an individual can opt to stay via self-pay. BHDDH-funded recovery community centers offer an additional supportive environment by providing a community of individuals in recovery additional support and training to help people live productive, fulfilling lives. On the AskRI website, there is a list of compiled resources forming a Recovery Resource Hub in alignment with SAMHSA's 8 Dimensions of Wellness. The state also funds a peer recovery specialist-specific training and technical assistance center that helps peers with getting all the necessary education and experience, including assistance with finding internships, to achieve and maintain certification.

8. Describe other state priorities or activities that the state plans to fund during the performance period of September 1, 2021 through September 30, 2025 using ARPA funds.

Other programs currently included for funding that are state priorities or activities include the funding of a graduate assistantship to help lead the Block grant needs assessment process. Over the last few years, BHDDH has been working on manualizing the process for replicability; however, COVID-19 threw the process for a loop as we reduced activities to maintain student safety. In partnership with URI, we've been able to build relationships with students that have led to employment opportunities with BHDDH and our state's community mental health centers, so far. Our hope is this program continues to be a workforce development initiative that trains university students on substance use and mental health issues and exposes them to the providers who help clients with related diagnoses. The only other initiative not previously discussed is the state level memberships for the National Grants Management Association and National Association for Addiction Professionals. These two associations have been identified as a great support to state staff in staying current on grants management principles such as risk assessments and active contract monitoring and the newest trends and tools associated with addiction respectively.

9. Describe your state plans for enhancing your state's prevention infrastructure which may include incorporating work around ACEs and improving substance misuse outcomes among young adults and older adults. (Primary Prevention set-aside)
a. The impact of increased access to marijuana and the state's strategies to prevent misuse by the underage population.
b. Strategies to reduce the COVID-19 impact of increased alcohol accessibility and misuse.
c. How the state is using equitable strategies to reduce disparities in the state's prevention planning and approaches.

- In the last COVID-19 supplement, we requested funds for our regional prevention coalitions to implement adverse childhood experiences (ACES) prevention programming called Incredible Years. This work is intended to continue under the regular Block grant allocations.
- Also, in the last COVID-19 supplement, we requested funds to create a marijuana prevention campaign for young adults due to the possibility of our state legalizing recreational marijuana in the near future. This campaign is statewide and is in the planning process currently. The Partnerships for Success grant is increasing efforts around preventing underage alcohol use by focusing on environmental and education strategies that address issues such as social host law,

youth retail access (including recent law changes permitting alcohol deliveries and alcohol take-out from restaurants), positive peer perception of underage alcohol use, and positive parent perception of underage alcohol use.

- Part of the reason for statewide implementation of student assistance counselors in all middle and high schools is to reduce disparities in programming, promoting equality in the provision of this program. Once established, our hope is to ascertain if additional resources are needed, particularly in schools with lower socioeconomic status and with more diverse racial and ethnic backgrounds when compared to the average demographics for the state in the U.S. census.

10. Describe how the state will use, or considered, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support SUD clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and should consider standards identified in the Interoperability Standards Advisory (https://www.healthit.gov/isa/), including but not limited to those standards described in the "Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data" section and the "Social Determinants of Health" section.

Rhode Island does not request funds for health IT infrastructure or advancement on this COVID-19 related supplemental funding. Currently, there are multiple efforts to do this work on a discretionary grant to the Executive Office of Health and Human Services' Capacity Building Infrastructure grant and other COVID-19 related funding requested through our Governor's Office.

Category	**Total Proposed Cost**
Personnel	$382,648
Fringe	$225,762
Travel	$0
Equipment	$0
Supplies	$0
Contractual	$5,542,506
Service Capacity Investments	*$4,122,455*
Workforce Development Investments	*$435,000*
Equity and Stigma Reduction Investments	*$985,051*
Total Direct Costs	$6,150,916
Total Indirect Costs	$0
Total Project Costs	**$6,150,916**

Personnel **$382,648**

- 0.50FTE Invoice Processing Support: $*73,709*

The position of a business management officer will be hired and serve 0.50FTE on the MH Block Grant and 0.50FTE on the SA Block grant to support the influx of contract development, invoice processing, and fiscal management that will occur with these supplemental funds. This person will be hired as a state employee to be able to access RIFANS. This position is applied to the 5% administrative cap. [Salary of $58,967 0.50FTE * 2.5 year cycle]*

- 0.50FTE Contract Monitoring Support: $*82,119*

One programming services officer position will be hired and serve 0.50FTE on the MH Block Grant and 0.50FTE on the SA Block grant (billed to grants in accordance with staff time tracking) to support the influx of contracts that will need monitoring including invoice approval and programmatic management that will occur with these supplemental funds. This position is applied to the 5% administrative cap. [Salary of $65,695 0.5FTE * 2.5 year cycle]*

- 0.50FTE Planning/Quality Assurance Support: $*85,342*

One associate administrator will be hired and serve 0.50FTE on the MH Block Grant and 0.50FTE on the SA Block grant (billed to grants in accordance with staff time tracking) to support the influx of complex planning for the CCBHC and crisis infrastructure work. This position will conduct clinical quality audits with CMHCs as needed and help with the planning and coordination associated with these larger programs. This falls under resource development and is not applied to the 5% administrative cap. [Salary of $68,274 0.5FTE * 2.5 year cycle]*

- *0.5FTE Evaluation Support: $141,478*

One evaluator will be hired to provide outcome evaluation support on the larger projects such as the CAHOOT/CCBHC-embedded crisis intervention pilot, court-ordered outpatient They will also provide process evaluation support on all programs to ensure evidence-based programs are being evaluated for fidelity and for any effects on intermediating factors that contribute to a reduction in substance use or an increase in quality of life indicators for consumers of mental health or substance use programs. This is a new position, not included in the previous supplement, and is budgeted for the length of the project at 0.5FTE on the MH Block grant and 0.5FTE on the SA Block grant. Furthermore, this role is attributable to resource development. [Salary of $70,739.5FTE*4 year cycle]*

Fringe **$225,762**

- Average fringe rate: 59%

Average fringe rate for BHDDH staff is 59%, and that includes FICA, retirement, insurance, and other benefits depending on employee salary level and personal selection. (.59 total personnel cost)*

Travel **$0**

- No requested funds

Equipment **$0**

- No requested funds

Supplies **$0**

- No requested funds

Contractual **$5,542,506**

Below is a table to explain how any required set asides would be met followed by budget narratives per program/intervention by investment category type:

Required Set Aside	Programs Included in Required Set-Aside	Total Cost of Set Aside
20% Primary Prevention Minimum ($1.2M)	• Statewide footprint of Student Assistance Services ($1.78M)	$1,783,455

Service Capacity Investments $4,122,455

- Crisis response infrastructure

Funds to support embedding the crisis work in the CCBHC model including the CAHOOTs or a modified crisis response pilot. CAHOOTS originated in Eugene, Oregon and stands for Crisis Assistance Helping Out on the Streets. It's a mobile crisis intervention program that provides support for police departments by taking on social service types calls including crisis counseling. They provide initial contact and transport for individuals with SMI as well as those that are disoriented or even intoxicated, freeing up the police departments to protect and serve communities for non-behavioral healthcare calls. Costs are estimated at $2M annually for startup for two communities and are shared across the MH and SA block grants with room for integration.

- Homeless/street outreach

Funds are to expand on the Projects for Assistance in Transition from Homelessness (PATH) grant, which focuses on providing services for individuals with serious mental illness experiencing homelessness. These individuals tend to use high-cost services such as emergency rooms and hospitalization stays that the PATH grant can help divert them from towards lower-cost, better fitting programs and services. The PATH award does not address those with substance use disorders so this supplement will be to *work specifically with individuals who have a substance use diagnosis* and allow them to do some case management and care coordination for substance use disorders. This was recommended by the RI Executive Office of Health and Human Services and supported by BHDDH staff as well.

- Naloxone Hub for Distribution and Education

BHDDH, in partnership with RI Department of Health, would fund a naloxone distribution hub. This hub would help streamline naloxone distribution to peer recovery specialists, recovery community centers, and others while providing education on how to administer naloxone and the importance of naloxone. Further efforts may be undertaken to link this initiative to Recovery Friendly Workplaces and the Governor's Overdose Task Force Rescue Workgroup as appropriate. It's expected to cost approximately $200,000 annually.

- WAVE Card Program with RI Department of Corrections

Funds to cover the cost of RI public transportation or Uber/taxi services to SUD treatment appointments for clients not covered by Medicaid or other insurance programs upon exit from the Department of Corrections. The cost of this program is project to be in the low five figures.

- Creation of ASAM LOC Initial Placement Tool

These funds would allow the creation of a screening tool to properly place individuals with substance use disorder in the proper level of care. This is the second piece of a project that's already begun and is

like other software available but without the annual subscription charge at an estimate cost around $90,000.

- Statewide footprint of Student Assistance Services

Funds to expand Student Assistance Services to all middle and high schools starting from the end date of the first supplement (3/14/23) through the end of the award (9/30/2025). Student Assistance includes an evidence-based curriculum, classroom presentations, community outreach and education, faculty/school personnel outreach, parent education and outreach, school or gradewide activities, student club meetings, and student outreach through attendance. Costs have been projected based on number of school years, number of schools, and full statewide implementation at just under $1.8M for the length of this award. While Student Assistance Services comprehensively addresses at least three CSAP strategies—Education, Problem Identification and Referral, and Information Dissemination—it is expected that the regional prevention task forces will continue their focus on Alternative Events, Community-Based Process, and Environmental Strategies. Environmental Strategies and Education will receive additional attention through the current Strategic Prevention Framework Partnerships for Success discretionary grant with a full review as we get closer to the end date of that grant. Currently, primary prevention activities account for at least 40% of the SAPT Block grant and an additional 29% of this supplement.

Workforce Development Investments $435,000

- Block Grant needs assessment graduate assistantship

This position is shared with the MH block grant to ensure a graduate student can lead the annual needs assessment process required in the combined SA/MH Block Grant needs assessment process. This workforce development initiative would be created through an expansion of an MOU we hold with the University of Rhode Island and would formalize a process we've done for the last two cycles. It's includes both spring and fall semester with 20 hours a week in the summer for two years. This would allow for 2 additional school years and to complete the school year from the first supplement.

- Peer Recovery Specialists Internships and Certification Fees

We've seen a low recertification rate for peer recovery specialists through the RI Certification Board. To reduce the financial burden, BHDDH proposes to contract with the RI Certification Board to pay fees for certification, recertification, and testing as needed. This could be expanded to other positions through the RI Certification Board such as counselors and clinical supervisors. This is popular among providers. To get certified, peer recovery specialists must complete an internship which has been historically unpaid, making it hard for those of different racial, ethnic, and socioeconomic backgrounds to become certified peers. These funds will support 10 paid internships and 1 paid full-time internship supervisor to increase our cadre of certified peer recovery specialists and expand to a more diverse workforce.

- National Grants Management Association (NGMA) organizational membership

These funds are to support up to seven staff from our fiscal and grants department in receiving additional training on grants management including auditing, federal regulations, risk assessments, and other grants management principles.

- National Association for Addiction Professionals (NAADAC) organizational membership

These funds are to support up to ten staff from our clinical division in receiving additional training on new evidence-based programs, strategies, theories, and other content for substance use disorder treatment professionals. It's $750 for three renewals plus $85 per individual

Equity and Stigma Reduction Investments $985,051

- Implementation of the Imani Breakthrough Project, a Promising Evidence-Informed Practice

Imani Breakthrough assists RI in reaching Black, Indigenous, People of Color (BIPOC) community members who are at elevated risk for overdose through trusted messengers in the faith community. It will also support other equity-focused program expansions identified through public procurement.

- Consultation for Development of a Race/Equity Strategic Plan

RI Executive Office of Health and Human Services requests assistance to facilitate the development of an action plan for racial and ethnic equity across Rhode Island on the continuum from primary prevention through treatment, overdose prevention, and recovery.

Total Direct Charges: **$6,150,916**

Indirect Charges: **$0**

- No requested funds

Total Project Costs: **$6,150,916**

State Information

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

Fiscal Year 2022

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
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**
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

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 Costal 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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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

Daniel J. McKee
Governor

July 1, 2021

Ms. Wendy Pang
Mr. Yan Rong
Grants Management Specialists
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857

Dear Ms. Pang and Mr. Rong:

I am writing to notify you that Richard Charest, director of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, is authorized as my designee to sign any required documents related to the Projects for Assistance in Transition from Homelessness (PATH) grant, and the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants (including the annual Synar report) for the tenure of my term as Governor of the State of Rhode Island.

Sincerely,

Daniel J. McKee
Governor of Rhode Island

State: *Rhode Island*
Grant: *Substance Abuse Prevention & Treatment Block Grant (SA Block Grant)*
Project: *Supplemental COVID-19 Funding*
Project Period: *9/1/2021-9/30/2025*
Total Allowable Budget: *$**6,150,916***

1. Identify the needs and gaps of your state's SUD services continuum, related to developing a comprehensive prevention, intervention, treatment, and recovery support services continuum.

The needs of Rhode Island's SUD service continuum include:

- Prevention: The lack of statewide implementation of Student Assistance Services, which covers a minimum of three CSAP strategies including education, problem identification and referral, and information dissemination. The fear has been that implementation of this program is lacking in some of the highest need areas of the state still due to funding limitations. We hope to address that with these funds while in turn meeting the required 20% set aside for primary prevention services. The regional prevention task forces continue to support all six CSAP strategies, with strong success around environmental strategies, alternative events, information dissemination, and community-based process continuing throughout the COVID-19 pandemic. Through PFS funding, additional efforts are placed on environmental and education strategies in 20 high-need communities.

- Intervention: A high need in our state system (and of primary focus through these supplemental funds) is around mobile crisis infrastructure. In the last proposal, Rhode Island proposed a Crisis Assistance Helping Out on the Streets (CAHOOTS) pilot to start this work. Additional funds will be requested to support this model and consideration of other models for statewide implementation to address the need and gap in system infrastructure. In alignment with this mobile crisis issue, a need for Crisis Intervention Training for first responders also was outlined. We added it to the proposal for the first COVID-19 supplemental dollars under our Mental Health Block grant but for the second supplement, we left it out as a discretionary grant for early diversion is working on statewide implementation of this training for first responders, including police officers. Outreach has also been identified as an issue, as we currently employ outreach teams through our state's PATH grant but due to funding limitations, they cannot work directly with client who do not have at least one mental health-related diagnosis. To reduce duplication of services, it makes sense to fund the same teams already in these communities to continue serving all homeless individuals regardless of diagnosis and expand the program.

- Treatment: It's been noted by membership of our state's Governor's Council on Behavioral Health that alcohol use disorder has not gotten the same attention as opioid use disorder in years past. Also, needs were expressed around the importance of providing SUD services in different settings such as jails, shelters, emergency departments, and federally qualified health centers, to name a few. Maintenance in treatment programs, especially medication assisted treatment, is also documented as a need.

- Recovery: Increasing the number of certified peer recovery specialists in Rhode Island. The goal of the Governor's Overdose Task Force is 200 trained and certified peers for the state. Another need is to strengthen the state's recovery community centers outreach, education, and

coordination efforts including naloxone and fentanyl test strip distribution. Another need is to support people with lived experience who lead peer-support organizations to receive the education and support they need to self-sustain. Furthermore, we wish to support more individuals with lived experience to increase their resilience so that the recovery community can continue to strengthen.

- Needs Across the Continuum: Understanding how to consider racial and ethnic equity in implementing all programs from prevention through recovery is a high need, and a current gap in our system. Barriers to SUD services recently identified (or reiterated) through this year's Combined SAPT/CMHS Block grant activities include stigma, transportation, not knowing how to access services, the cost of services, services offered at inconvenient times, racial and ethnic differences, and not providing services in a trauma responsive way. Transportation and housing are two very large issues that we're still trying to find ways to address. With housing not being the purpose of this Block grant, we sought other funding sources to continue our recovery housing program.

2. Describe how your state's spending plan proposal will address the state's substance use disorder services continuum, including a budget that addresses the needs and gaps related to this continuum.

Please see the budget breakdown below to answer this question.

3. Describe your state's progress in addressing the rising drug overdose rate in many parts of the country, and what steps the state will be taking to improve access to SUD treatment, by improving identification of persons in need, reducing barriers to admission to treatment, and strengthening mechanisms to promote client engagement and retention in SUD treatment and recovery support services.

Rhode Island saw a reduction in drug overdose until November 2019 and continued to climb through COVID-19 pandemic. As services began opening again in the winter of 2020, we did see a slight decline in overdose deaths but we're still above the average we were pre-pandemic. BHDDH is funding outreach teams through our state's health department with State Opioid Response (SOR) grant supplement in addition to the outreach service expansion proposed below as part of the PATH extension to cover individuals experience homelessness that have a substance use disorder diagnosis. The funding of a naloxone hub would also help centralize naloxone distribution to reduce waste and overlap while providing education and resources around the use of naloxone and fentanyl test strips. To help streamline the assessment process, we're also working on the development of an ASAM assessment tool that should improve identification of persons in need in addition to the correct level of care for them based on the ASAM criteria. One need that didn't make the cut for funding was piloting a contingency management program. Despite it not being currently in the plan, if other items come in under budget, the hope is to revise the plan to include this pilot for the sake of assisting clients in adhering to their treatment plans, specifically around medication-assisted treatment programs. It was a priority identified by SUD provider and Brown University alike and would fit well with promoting client engagement and retention.

4. Describe your state's progress in implementing the increased and widespread use of FDA approved medications for the treatment of opioid use disorder, alcohol use disorder, and tobacco use disorder, in combination with other substance use disorder evidence-based

treatments and practices.

Overall, the number of individuals receiving medication-assisted treatment has been increasing steadily over the past few years. According to PreventOverdoseRI.org, buprenorphine has increased from 4,355 individuals at the beginning of calendar year 2017 to 5,588 individuals in the beginning of calendar year 2021. Methadone has also been on rise from 5,293 individuals in the beginning of calendar year 2017 to 6,078 individuals in the beginning of calendar year 2021. Buprenorphine treatment capacity has more than doubled in Rhode Island since 2016, as the number of trained and data-waivered medical professionals has steadily risen. However, the number of providers offering Vivitrol (extended release naltrexone) is lower. Naltrexone can be provided through the following treatment providers: Codac Behavioral Healthcare, Inc., Meadows Edge Recovery Center, East Coast Medical, Medical Assisted Recovery, Inc., and the Journey to Hope, Health and Healing. Nicotine replacement therapy is encouraged during the assessment process at substance use disorder providers if a client indicates they use tobacco, and additional work has been done around the creation and implementation of this protocol, and additional Tobacco Treatment Specialist training and training-of-trainers, in the last two years.

5. Explain how your state plans to collaborate with other departments or agencies to address the SUD services continuum.

BHDDH frequently partners with the state's department of health and state's department of corrections on programs related to substance use disorder. In the budget below, you'll see a transportation initiative with the department of corrections to help individuals who have left the corrections system get around to their SUD treatment appointments and initiate or continue participation in the SUD recovery activities. We will continue to co-chair the Governor's Overdose Task Force with the department of health, which is where the genesis of the naloxone hub concept began. We also will work with the Executive Office on Health and Human Services on strategic planning for race and equity across the SUD services continuum.

6. Describe how the state plans to use SABG ARPA funding to promote health equity among identified underserved populations, and how it plans to address health disparities in the planning, delivery, and evaluation of SUD prevention, intervention, treatment, and recovery support services.

To help answer this question, the budget below breaks down a series of investments around race and equity across the continuum of care. In particular, the work towards developing an actionable strategic plan specific to race equity is very important to our state. The statewide implementation of student assistance services in all middle and high schools is needed to address possible disparities due to socioeconomic status. The Imani Breakthrough Project is focused on addressing equity issues and stigma in the faith-based community. If, upon completion of the strategic planning process, programmatic needs are identified, the state will move forward to address those needs with any underspent funds on this supplement to help maximize the impact of this funding on increasing health equity for Rhode Islanders across the SUD service continuum.

7. Describe the state's efforts and plans to promote an increased emphasis on the development, delivery, and support of widespread SUD recovery support services, systems, and mechanisms across the state.

In Rhode Island, there are several recovery related initiatives to create a statewide service of recovery supports. First, through the State Opioid Response (SOR) grant and other dollars through the state, we're able to offer recovery housing to individuals who need a substance-free environment to live while in recovery. The state pays for this on a sliding scale over the course of one year, at which point an individual can opt to stay via self-pay. BHDDH-funded recovery community centers offer an additional supportive environment by providing a community of individuals in recovery additional support and training to help people live productive, fulfilling lives. On the AskRI website, there is a list of compiled resources forming a Recovery Resource Hub in alignment with SAMHSA's 8 Dimensions of Wellness. The state also funds a peer recovery specialist-specific training and technical assistance center that helps peers with getting all the necessary education and experience, including assistance with finding internships, to achieve and maintain certification.

8. Describe other state priorities or activities that the state plans to fund during the performance period of September 1, 2021 through September 30, 2025 using ARPA funds.

Other programs currently included for funding that are state priorities or activities include the funding of a graduate assistantship to help lead the Block grant needs assessment process. Over the last few years, BHDDH has been working on manualizing the process for replicability; however, COVID-19 threw the process for a loop as we reduced activities to maintain student safety. In partnership with URI, we've been able to build relationships with students that have led to employment opportunities with BHDDH and our state's community mental health centers, so far. Our hope is this program continues to be a workforce development initiative that trains university students on substance use and mental health issues and exposes them to the providers who help clients with related diagnoses. The only other initiative not previously discussed is the state level memberships for the National Grants Management Association and National Association for Addiction Professionals. These two associations have been identified as a great support to state staff in staying current on grants management principles such as risk assessments and active contract monitoring and the newest trends and tools associated with addiction respectively.

9. Describe your state plans for enhancing your state's prevention infrastructure which may include incorporating work around ACEs and improving substance misuse outcomes among young adults and older adults. (Primary Prevention set-aside)
a. The impact of increased access to marijuana and the state's strategies to prevent misuse by the underage population.
b. Strategies to reduce the COVID-19 impact of increased alcohol accessibility and misuse.
c. How the state is using equitable strategies to reduce disparities in the state's prevention planning and approaches.

- In the last COVID-19 supplement, we requested funds for our regional prevention coalitions to implement adverse childhood experiences (ACES) prevention programming called Incredible Years. This work is intended to continue under the regular Block grant allocations.
- Also, in the last COVID-19 supplement, we requested funds to create a marijuana prevention campaign for young adults due to the possibility of our state legalizing recreational marijuana in the near future. This campaign is statewide and is in the planning process currently. The Partnerships for Success grant is increasing efforts around preventing underage alcohol use by focusing on environmental and education strategies that address issues such as social host law,

youth retail access (including recent law changes permitting alcohol deliveries and alcohol take-out from restaurants), positive peer perception of underage alcohol use, and positive parent perception of underage alcohol use.

- Part of the reason for statewide implementation of student assistance counselors in all middle and high schools is to reduce disparities in programming, promoting equality in the provision of this program. Once established, our hope is to ascertain if additional resources are needed, particularly in schools with lower socioeconomic status and with more diverse racial and ethnic backgrounds when compared to the average demographics for the state in the U.S. census.

10. Describe how the state will use, or considered, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support SUD clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and should consider standards identified in the Interoperability Standards Advisory (https://www.healthit.gov/isa/), including but not limited to those standards described in the "Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data" section and the "Social Determinants of Health" section.

Rhode Island does not request funds for health IT infrastructure or advancement on this COVID-19 related supplemental funding. Currently, there are multiple efforts to do this work on a discretionary grant to the Executive Office of Health and Human Services' Capacity Building Infrastructure grant and other COVID-19 related funding requested through our Governor's Office.

Category	**Total Proposed Cost**
Personnel	$382,648
Fringe	$225,762
Travel	$0
Equipment	$0
Supplies	$0
Contractual	$5,542,506
Service Capacity Investments	*$4,122,455*
Workforce Development Investments	*$435,000*
Equity and Stigma Reduction Investments	*$985,051*
Total Direct Costs	$6,150,916
Total Indirect Costs	$0
Total Project Costs	**$6,150,916**

Personnel **$382,648**

- 0.50FTE Invoice Processing Support: $*73,709*

The position of a business management officer will be hired and serve 0.50FTE on the MH Block Grant and 0.50FTE on the SA Block grant to support the influx of contract development, invoice processing, and fiscal management that will occur with these supplemental funds. This person will be hired as a state employee to be able to access RIFANS. This position is applied to the 5% administrative cap. [Salary of $58,967 0.50FTE * 2.5 year cycle]*

- 0.50FTE Contract Monitoring Support: $*82,119*

One programming services officer position will be hired and serve 0.50FTE on the MH Block Grant and 0.50FTE on the SA Block grant (billed to grants in accordance with staff time tracking) to support the influx of contracts that will need monitoring including invoice approval and programmatic management that will occur with these supplemental funds. This position is applied to the 5% administrative cap. [Salary of $65,695 0.5FTE * 2.5 year cycle]*

- 0.50FTE Planning/Quality Assurance Support: $*85,342*

One associate administrator will be hired and serve 0.50FTE on the MH Block Grant and 0.50FTE on the SA Block grant (billed to grants in accordance with staff time tracking) to support the influx of complex planning for the CCBHC and crisis infrastructure work. This position will conduct clinical quality audits with CMHCs as needed and help with the planning and coordination associated with these larger programs. This falls under resource development and is not applied to the 5% administrative cap. [Salary of $68,274 0.5FTE * 2.5 year cycle]*

- *0.5FTE Evaluation Support: $141,478*

One evaluator will be hired to provide outcome evaluation support on the larger projects such as the CAHOOT/CCBHC-embedded crisis intervention pilot, court-ordered outpatient They will also provide process evaluation support on all programs to ensure evidence-based programs are being evaluated for fidelity and for any effects on intermediating factors that contribute to a reduction in substance use or an increase in quality of life indicators for consumers of mental health or substance use programs. This is a new position, not included in the previous supplement, and is budgeted for the length of the project at 0.5FTE on the MH Block grant and 0.5FTE on the SA Block grant. Furthermore, this role is attributable to resource development. [Salary of $70,739.5FTE*4 year cycle]*

Fringe **$225,762**

- Average fringe rate: 59%

Average fringe rate for BHDDH staff is 59%, and that includes FICA, retirement, insurance, and other benefits depending on employee salary level and personal selection. (.59 total personnel cost)*

Travel **$0**

- No requested funds

Equipment **$0**

- No requested funds

Supplies **$0**

- No requested funds

Contractual **$5,542,506**

Below is a table to explain how any required set asides would be met followed by budget narratives per program/intervention by investment category type:

Required Set Aside	Programs Included in Required Set-Aside	Total Cost of Set Aside
20% Primary Prevention Minimum ($1.2M)	• Statewide footprint of Student Assistance Services ($1.78M)	$1,783,455

Service Capacity Investments $4,122,455

- Crisis response infrastructure

Funds to support embedding the crisis work in the CCBHC model including the CAHOOTs or a modified crisis response pilot. CAHOOTS originated in Eugene, Oregon and stands for Crisis Assistance Helping Out on the Streets. It's a mobile crisis intervention program that provides support for police departments by taking on social service types calls including crisis counseling. They provide initial contact and transport for individuals with SMI as well as those that are disoriented or even intoxicated, freeing up the police departments to protect and serve communities for non-behavioral healthcare calls. Costs are estimated at $2M annually for startup for two communities and are shared across the MH and SA block grants with room for integration.

- Homeless/street outreach

Funds are to expand on the Projects for Assistance in Transition from Homelessness (PATH) grant, which focuses on providing services for individuals with serious mental illness experiencing homelessness. These individuals tend to use high-cost services such as emergency rooms and hospitalization stays that the PATH grant can help divert them from towards lower-cost, better fitting programs and services. The PATH award does not address those with substance use disorders so this supplement will be to *work specifically with individuals who have a substance use diagnosis* and allow them to do some case management and care coordination for substance use disorders. This was recommended by the RI Executive Office of Health and Human Services and supported by BHDDH staff as well.

- Naloxone Hub for Distribution and Education

BHDDH, in partnership with RI Department of Health, would fund a naloxone distribution hub. This hub would help streamline naloxone distribution to peer recovery specialists, recovery community centers, and others while providing education on how to administer naloxone and the importance of naloxone. Further efforts may be undertaken to link this initiative to Recovery Friendly Workplaces and the Governor's Overdose Task Force Rescue Workgroup as appropriate. It's expected to cost approximately $200,000 annually.

- WAVE Card Program with RI Department of Corrections

Funds to cover the cost of RI public transportation or Uber/taxi services to SUD treatment appointments for clients not covered by Medicaid or other insurance programs upon exit from the Department of Corrections. The cost of this program is project to be in the low five figures.

- Creation of ASAM LOC Initial Placement Tool

These funds would allow the creation of a screening tool to properly place individuals with substance use disorder in the proper level of care. This is the second piece of a project that's already begun and is

like other software available but without the annual subscription charge at an estimate cost around $90,000.

- Statewide footprint of Student Assistance Services

Funds to expand Student Assistance Services to all middle and high schools starting from the end date of the first supplement (3/14/23) through the end of the award (9/30/2025). Student Assistance includes an evidence-based curriculum, classroom presentations, community outreach and education, faculty/school personnel outreach, parent education and outreach, school or gradewide activities, student club meetings, and student outreach through attendance. Costs have been projected based on number of school years, number of schools, and full statewide implementation at just under $1.8M for the length of this award. While Student Assistance Services comprehensively addresses at least three CSAP strategies—Education, Problem Identification and Referral, and Information Dissemination—it is expected that the regional prevention task forces will continue their focus on Alternative Events, Community-Based Process, and Environmental Strategies. Environmental Strategies and Education will receive additional attention through the current Strategic Prevention Framework Partnerships for Success discretionary grant with a full review as we get closer to the end date of that grant. Currently, primary prevention activities account for at least 40% of the SAPT Block grant and an additional 29% of this supplement.

Workforce Development Investments $435,000

- Block Grant needs assessment graduate assistantship

This position is shared with the MH block grant to ensure a graduate student can lead the annual needs assessment process required in the combined SA/MH Block Grant needs assessment process. This workforce development initiative would be created through an expansion of an MOU we hold with the University of Rhode Island and would formalize a process we've done for the last two cycles. It's includes both spring and fall semester with 20 hours a week in the summer for two years. This would allow for 2 additional school years and to complete the school year from the first supplement.

- Peer Recovery Specialists Internships and Certification Fees

We've seen a low recertification rate for peer recovery specialists through the RI Certification Board. To reduce the financial burden, BHDDH proposes to contract with the RI Certification Board to pay fees for certification, recertification, and testing as needed. This could be expanded to other positions through the RI Certification Board such as counselors and clinical supervisors. This is popular among providers. To get certified, peer recovery specialists must complete an internship which has been historically unpaid, making it hard for those of different racial, ethnic, and socioeconomic backgrounds to become certified peers. These funds will support 10 paid internships and 1 paid full-time internship supervisor to increase our cadre of certified peer recovery specialists and expand to a more diverse workforce.

- National Grants Management Association (NGMA) organizational membership

These funds are to support up to seven staff from our fiscal and grants department in receiving additional training on grants management including auditing, federal regulations, risk assessments, and other grants management principles.

- National Association for Addiction Professionals (NAADAC) organizational membership

These funds are to support up to ten staff from our clinical division in receiving additional training on new evidence-based programs, strategies, theories, and other content for substance use disorder treatment professionals. It's $750 for three renewals plus $85 per individual

Equity and Stigma Reduction Investments $985,051

- Implementation of the Imani Breakthrough Project, a Promising Evidence-Informed Practice

Imani Breakthrough assists RI in reaching Black, Indigenous, People of Color (BIPOC) community members who are at elevated risk for overdose through trusted messengers in the faith community. It will also support other equity-focused program expansions identified through public procurement.

- Consultation for Development of a Race/Equity Strategic Plan

RI Executive Office of Health and Human Services requests assistance to facilitate the development of an action plan for racial and ethnic equity across Rhode Island on the continuum from primary prevention through treatment, overdose prevention, and recovery.

Total Direct Charges: **$6,150,916**

Indirect Charges: **$0**

- No requested funds

Total Project Costs: **$6,150,916**

I. State Information

Chief Executive Officer's Funding Agreements, Assurances Non-Construction Programs and Certifications (Form 03)
Fiscal Year 2020/21

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 I 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 I of the Public Health Service Act

Section	Title	Chapter
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

Title XIX, Part B, Subpart III of the Public Health Service Act

Section	Title	Chapter
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

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I 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 which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

State: Rhode Island

Name of Chief Executive Officer (CEO) or Designee: RICHARD CHAREST

Signature of CEO or Designee[1]:

Title: DIRECTOR

Date Signed: 9/1/21
mm/dd/yyyy

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

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 sub agreements.

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 Costal 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.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. 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.

State: *Rhode Island*
Grant: *Block Grants for Community Mental Health Services (MH Block Grant)*
Project: *Supplemental ARPA Funding*
Project Period: *9/1/2021-9/30/2025*
Total Allowable Budget: ***$5,302,664***

1. The needs and gaps of Rhode Island's mental health services in the context of COVID-19 resulted in the following goals:1) increasing access to warm and crisis lines; 2) promotion of our 24/7 triage center for those in crisis to keep them out of emergency rooms that were at or exceeding capacity with COVID-19; 3) ensuring that individuals with mental illness had a safe place to stay and could still access services; 4) finding a way to address the increase in social isolation i.e. increasing outreach, intervention, and follow up for those in crisis. Essentially, the primary concerns revolved around an increased need at a time of pandemic, leading the state to want to make the process for getting individuals help as streamlined as possible. It also led to a housing crisis in which individuals experiencing homelessness had even less resources to turn to, and a hotel was turned into emergency housing for those in quarantine who had nowhere else to do. Social isolation was highly noted during this time as well, leading peers to be a critical resource for those with mental illness at this time. The primary difference focused on this application versus the COVID-19 application submitted back in April 2021 was the focus on moving towards implementing CCBHC standards within our CMHCs. It's our hope that this will help strengthen crisis infrastructure as well as increase the quality of mental health programming for individuals with serious mental illness, first episode psychosis, and serious persistent mental illness.

2. The implementation of 988 hotline has been more complex than initially perceived. This is a need that will continue over the life of this ARPA funding and is being worked on in conjunction with the RI Department of Health's Injury Prevention team. While we have had a 24/7 triage center up and running for more than a year now, the number of visits and phone calls remain less than initially projected. The coordination between the triage center and the CMHCs needs has been functioning well in most parts of the state but a gap in our mental health crisis services continuum include a fully functioning crisis outreach, intervention, and follow-up system. We indicated the use of the first COVID-19 funds to start a CAHOOTs pilot for those areas in the state where disbelief of the efficacy of a police response to behavioral health crisis calls is high. We also increased CIT training, but have since found other federal funds to create a statewide footprint of Crisis Intervention Training. This application expands the mobile crisis response teams, exploring a format tied closer to the CMHCs. Also, for areas in which crisis stabilization beds are needed, we can explore that through the funding set aside in this proposal under CCBHC by allowing our CMHCs to submit applications on what sectors of a CCHBC they need most to improve and allowing them to apply for those improvements. To do this, we can utilize our delegated authority with our CMHCs so they can design plans to enhance the areas of CCHBC they struggle most with.

3. To help describe how Rhode Island's spending plan, a current budget is proposed below. This budget includes outreach services to individuals experiencing homelessness and a focus on peer recovery specialist work in and out of recovery community centers to help reduce social isolation. The plan also well as increasing our mobile crisis response capacity through expansion of the CCBHC model as well as supporting court-ordered outpatient related services currently

unfunded. Due to guidance within BHDDH central management's planning division, the contractual line was split into two categories: service capacity investments and workforce development investments. Specific examples of this work is listed in each category (below).

4. Rhode Island will advance the development of crisis services based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit by focusing our attention on mobile crisis intervention and training, separately as its own budgeted item with potential enhancements through the CCBHC investments program. Strengthening peer organizations through the Leadership Fellows Academy and additional funds for recovery community centers will be critical to provide post-crisis support as well as help individuals with serious mental illness navigate through service delivery system. For children with SED, all those interventions currently budgeted are related to a warm line (Kid's Link) and mobile crisis infrastructure, as DCYF is currently implementing a work group to look at their system of care including crisis.

5. Rhode Island (BHDDH) will collaborate with RI Department of Health on suicide prevention planning including the implementation of 988. BHDDH will also collaborate with RI Department of Children, Youth, and Families on any programming that affects children with serious emotional disturbance, and with the PATH grant staff and their community providers to ensure that the homeless outreach program is implemented well. CIT training, CAHOOTS and other crisis training and intervention programming will be implemented with first responders including police officers, fire personnel, and other community staff. Furthermore, transportation between RI Department of Corrections (and parole staff) and mental health maintenance activities such as involvement with local recovery community centers will happen in the form of the WAVE cards for transportation (for non-Medicaid eligible, mental health-related travel).

6. The ten percent first episode psychosis will be dedicated to starting up a new modified coordinated specialty care site in the Pawtucket/Central Falls area (Gateway). This CSC program will be different than Healthy Transitions (HT), with a staffing pattern more similar to traditional coordinated specialty care programs. It's our hope to use this pilot to collect data and better understand the impact of the Healthy Transitions program versus this pilot of a staffing pattern more like CSC but smaller than HT. For the five percent set aside for crisis, over $1M of these funds are requested to continue crisis infrastructure as described below. Rhode Island is in an exploratory phase, trying to find the best format for crisis intervention and follow-up that utilizes our strengths and existing structure.

7. One state priority proposed for MH Block grant ARPA funding is around strengthening the rehabilitation and mental health maintenance community by increasing the number of certified peer recovery specialists and strengthen the footprint of recovery community centers as a mental health resource. The other state priority that's different than the first supplement is around statewide implementation of CCBHC. Currently, our state less than four CMHCs with CCBHC infrastructure grants. The resources SAMHSA provided directly to CMHCs has moved the needle but there is plenty more work to be done, especially by sites that have yet to receive these funds.

8. The state does not plan to use these funds for health IT infrastructure unless explicitly requested by a CMHC as part of the CCBHC investments planning process. There are other funds not from

SAMHSA being considered to fund some investments and until any further need becomes apparent, to be good stewards of the funds, we do not wish to duplicate efforts.

Category	**Total Proposed Cost**
Personnel	$382,648
Fringe	$225,762
Travel	$0
Equipment	$0
Supplies	$0
Contractual	$4,694,254
Service Capacity Investments	*$4,154,254*
Workforce Development Investments	*$540,000*
Total Direct Costs	$5,302,664
Total Indirect Costs	$0
Total Project Costs	**$5,302,664**

Personnel **$382,648**

- 0.50FTE Invoice Processing Support: $*73,709*

The position of a business management officer will be hired and serve 0.50FTE on the MH Block Grant and 0.50FTE on the SA Block grant to support the influx of contract development, invoice processing, and fiscal management that will occur with these supplemental funds. This person will be hired as a state employee to be able to access RIFANS. This position is applied to the 5% administrative cap. [Salary of $58,967 0.50FTE * 2.5 year cycle]*

- 0.50FTE Contract Monitoring Support: $*82,119*

One programming services officer position will be hired and serve 0.50FTE on the MH Block Grant and 0.50FTE on the SA Block grant (billed to grants in accordance with staff time tracking) to support the influx of contracts that will need monitoring including invoice approval and programmatic management that will occur with these supplemental funds. This position is applied to the 5% administrative cap. [Salary of $65,695 0.5FTE * 2.5 year cycle]*

- 0.50FTE Planning/Quality Assurance Support: $*85,342*

One associate administrator will be hired and serve 0.50FTE on the MH Block Grant and 0.50FTE on the SA Block grant (billed to grants in accordance with staff time tracking) to support the influx of complex planning for the CCBHC and crisis infrastructure work. This position will conduct clinical quality audits with CMHCs as needed and help with the planning and coordination associated with these larger programs. This falls under resource development and is not applied to the 5% administrative cap. [Salary of $68,274 0.5FTE * 2.5 year cycle]*

- 0.50FTE Evaluation Support: $141,478

One evaluator will be hired to provide outcome evaluation support on the larger projects such as the CAHOOT/CCBHC-embedded crisis intervention pilot, court-ordered outpatient They will also provide process evaluation support on all programs to ensure evidence-based programs are being evaluated for fidelity and for any effects on intermediating factors that contribute to a reduction in substance use or an increase in quality of life indicators for consumers of mental health or substance use programs. This is a new position, not included in the previous supplement, and is budgeted for the length of the project at 0.5FTE on the MH Block grant and 0.5FTE on the SA Block grant. Furthermore, this role is attributable to resource development and not the 5% administrative cap. [Salary of $70,739.5FTE*4 year cycle]*

Fringe **$225,762**

- Average fringe rate: 59%

Average fringe rate for BHDDH staff is 59%, and that includes FICA, retirement, insurance, and other benefits depending on employee salary level and personal selection. (.59 total personnel cost)*

Travel **$0**

- No requested funds

Equipment **$0**

- No requested funds

Supplies **$0**

- No requested funds

Contractual **$4,694,254**

Below is a table to explain how any required set asides would be met followed by budget narratives per program/intervention by investment category type:

Required Set Aside/Cap	Programs Included in Required Set-Asides	Total Cost of Set Asides
5% Crisis Services Minimum ($265K)	• Crisis response infrastructure ($1.15M)	$1,150,000
10% First Episode Psychosis Minimum ($531K)	• Supplemental Healthy Transitions funding ($531K)	$531,000
10% Children with Serious Emotional Disturbance (SED) Minimum ($531K)	• Evidence Based Programs, HomeBuilders and Strong African American Families ($531K)	$531,000
5% Administrative Cap ($265K)	• .5FTE Invoice Processing Support Salary and Fringe ($117K) • .5FTE Contract Monitoring Support Salary and Fringe ($131K)	$248,000

Service Capacity Investments $4,154,254

- Crisis response infrastructure

Funds to support embedding the crisis work in the CCBHC model including the CAHOOTs or a modified crisis response pilot. CAHOOTS originated in Eugene, Oregon and stands for Crisis Assistance Helping Out on the Streets. It's a mobile crisis intervention program that provides support for police departments by taking on social service types calls including crisis counseling. They provide initial contact and transport for individuals with SMI as well as those that are disoriented or even intoxicated, freeing up the police departments to protect and serve communities for non-behavioral healthcare calls. Costs are estimated at $2M annually for startup for two communities and are shared across the MH and SA block grants with room for integration.

- Supplemental Healthy Transitions funding

Funds are to support the creation of a new Healthy Transitions site in the state or to supplement existing sites by providing additional coordination for wraparound services or the creation of a training institute.

- Evidence-Based Programs, Homebuilders and Strong African American Families (SAAF)

Through a Memorandum of Understanding with the RI Department of Children, Youth, and Families (DCYF), we will implement two evidence-based programs with specific subpopulations of children with serious emotional disturbance. Strong African American Families (SAAF) is a 7-session program designed for youth aged 10–14 and their caregivers that's culturally sensitive. Homebuilders is intensive home-based services to prevent first-time out-of-home care placement when it is imminent to get kids back home within seven days of the start of the program. Both programs were requested by DCYF for funding.

- CCBHC Infrastructure Investments

Funds CCBHCs to undertake new service delivery models for sustained treatment of mental health conditions in anticipation of expected increase in co-occurring disorders and exacerbated mental health diagnosis triggers. Includes Individual Placement Services (IPS) training and implementation to improve employment outcomes and internship development and placement programs for community mental health centers.

- Court-ordered psychiatry consults

Because court-ordered outpatient is not a billable expense unless the assessment matches the level of care required by the courts, court-ordered psychiatry consults are not billable. This is necessary to ensure psychiatrists are available and initiate treatment as well as provide consultations for second opinions. Budget is generated from the telehealth rates for psychiatric consultations and should provide better care for one of the primary populations of the MH Block Grant, individuals with serious mental illness. Budget includes 25 hours a week for psychiatry availability plus Mental Health Court availability. This is for individuals with SMI and SPMI diagnoses.

- WAVE Card Program with RI Department of Corrections

Funds to cover the cost of RI public transportation or Uber/taxi services to SUD treatment appointments for clients not covered by Medicaid or other insurance programs upon exit from the Department of

Corrections. The cost of this program is project to be in the low five figures. This is for individuals with SMI or SMI with a co-occurring diagnosis.

Workforce Development Investments *$540,000*

- Peer Recovery Specialists: Leadership Fellows Academy and Certification Fee Pool

This is for a cohort of 12-15 peer leaders to attend a year long technical assistance and training program that develops leadership capacity for executive directors and board chairs of consumer operated nonprofits to strengthen the leadership ability of peers across the state for multiple years. It's also to help nonprofits learn how to make the most of their budgets and fundraise, reducing reliance on dollars from state agencies. This is continued from the first supplement, starting 3/15/2023 to 9/30/2025. Also, we've seen a low recertification rate for peer recovery specialists through the RI Certification Board. To reduce the financial burden, BHDDH proposes to contract with the RI Certification Board to pay fees for certification, recertification, and testing as needed. This could be expanded to other positions through the RI Certification Board such as counselors and clinical supervisors. This is popular among providers.

- Training fees for Substance Use Mental Health Leadership Council trainings for frontline Mental Health providers

With many of these positions being paid at or just over minimum wage despite education and certification requirements, BHDDH proposes to add funds to an existing contract to pay the $30 per person fee each provider or their staff would pay to attend necessary trainings. This is popular among providers.

- Block Grant needs assessment graduate assistantship

This position is shared with the SA block grant to ensure a graduate student can lead the annual needs assessment process required in the combined SA/MH Block Grant needs assessment process. This position would be created through an expansion of an MOU we hold with the University of Rhode Island and would formalize a process we've done for the last two cycles. It's approximately $70K annually, includes both spring and fall semester with 20 hours a week in the summer for two and half years, starting from 3/14/2023 and continuing through 9/30/2025, included in this budget.

Total Direct Charges: $5,302,664

Indirect Charges: *$0*

- No requested funds

Total Project Costs: **$5,302,664**

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

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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

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 (RIDOH); Human Services (DHS); Children, Youth and Families (DCYF); and Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). BHDDH provides direct services to nearly 45,000 Rhode Islanders as well as an array of regulatory, protective and health promotion services to our communities. Health and human services benefits represent $4.1 billion spending per year, approximately 40 percent of the entire state budget. In 2014, the State consolidated 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 for the 2017 legislative session which became State of Rhode Island law § 40.1-1-13. Powers and duties of the office pertaining to Behavioral Healthcare, Developmental Disabilities, and Hospitals.

Health and Human Service Departments

Below is a brief overview of the organizational structure for the four Departments of Health and Human Services. BHDDH and DCYF serve as the lead agencies on this combined application for mental health, substance abuse prevention and treatment.

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 a full continuum of services. Through prevention, early intervention, treatment and recovery support, BHDDH promotes the health, safety and well-being of all Rhode Islanders by developing policies and programs that address developmental disabilities, mental illness, addiction, recovery and community support. Our 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, BHDDH is a champion 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. 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 **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'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 beginning in 2011. RIDOH has a substantial history of planning, implementing, and evaluating state-wide programs and providing RI communities and policy-makers with data and technical assistance to prevent drug overdose.

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

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 and again in July 2018, effective through December 2023.

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.

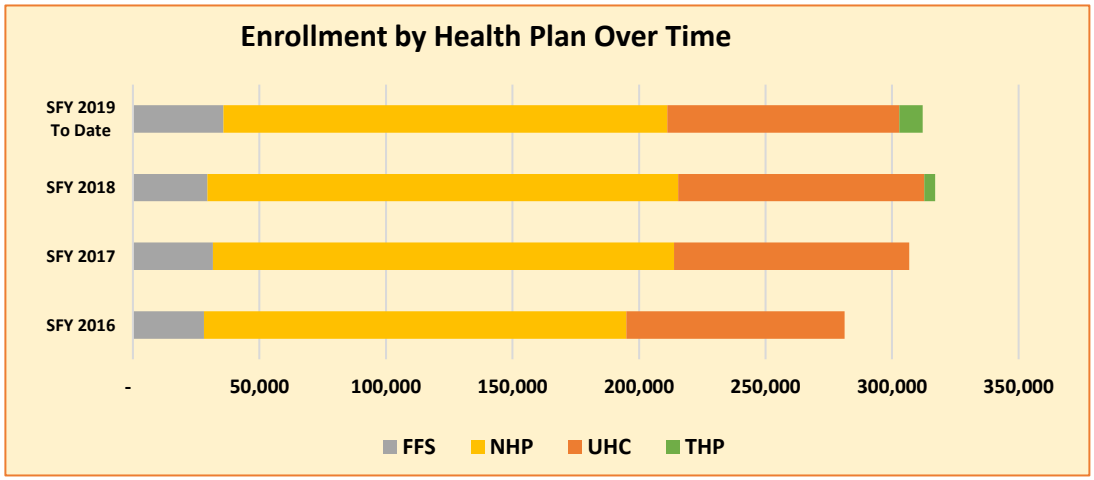
Rhode Island is strongly committed to managed care as a primary vehicle for the organization and delivery of Medicaid covered services to its eligible beneficiaries. Rhode Island has steadily increased the populations and services included in its managed care programs. When Medicaid began in the mid-1960s, 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 Medicaid enrollment by product line and by health plan for 2018, 2019, 2020 and 2021 (through June 30, 2021).

Medicaid Enrollment		2018	2019	2020	2021 (through 6/30/2021)
Medicaid Expansion		71,982	66,957	87,544	96,265
PACE		298	337	345	349
RHO Phase I		12,086	N/A	N/A	N/A
RHO Phase II		15,145	13,676	12,846	12,695
Rhody Health Partners		14,651	14,493	14,584	14,700
RIte Care		167,249	155,760	168,992	174,227
RIte Share		3,909	2,880	2,622	2,762
Total		**285,320**	**254,103**	**286,933**	**300,998**
Medicaid Enrollment by Health Plan	PACE	298	337	345	349
	FFS	37,722	39,636	38,658	35,659
	NHP	168,983	158,951	177,634	185,026
	UHC	90,603	83,045	92,370	96,344
	THP	9,441	8,890	13,962	16,517
	Total	**307,047**	**290,859**	**322,969**	**333,895**



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 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.

Rhode Island continues to operate certain programs including:

- 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. 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. Through March 15,2019, 292 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 22,000 Rhode Islanders over age 65 and individuals with disabilities/chronic conditions who have Medicaid coverage or Medicare and Medicaid coverage (dual eligibility) are eligible.

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.

89% of the eligible Medicaid population were enrolled in a Managed Care Program, 52% are enrolled through RIte Care, and 27% are enrolled through Medicaid expansion. In part, this is because most managed care enrollees are in the RIte Care program, which has a lower per member per month (PMPM) cost, than the elder or adult disabled populations. Rhode Island's participating Medicaid Managed Care plans have consistently been ranked among the best in the nation by the National Committee for Quality Assurance (NCQA)

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

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

Rhode Island's portal for application and enrollment in Medicaid is through HealthSource 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.

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.

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 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 Impact of the COVID-19 Pandemic on Rhode Island Children
The COVID-19 pandemic has hit Rhode Island hard, with the fourth highest per capita COVID-19 deaths in the nation. Low-income families and Families of Color in marginalized communities have been hit hardest both by the disease itself and the resulting economic crisis, which have exacerbated longstanding racial and ethnic disparities. The devastating effects of the pandemic on Rhode Island children and families' economic well-being, physical and mental health, safety, access to education, and educational outcomes as well as

the strategies that the federal government, state government, and community agencies have put in place to support Rhode Island children and families during the pandemic.

According to the RI kid's Count Fact Book Community Survey conducted by the U.S Census Bureau, there were 1,059,361 Rhode Island residents in 2019. Children under age 18 make up 19% of the population. Rhode Island's child population decreased from 247,822 in 2000to 223,956 in 2010 and then further to an estimated 203,575 in 2019 (18% decreased from 2000 to 2019). Between 2015 and 2019, there were 116,683 households with children under are age 18 in Rhode Island, representing 28% of all households. Twenty-six percent of Rhode Island children were under age five, 27% were ages five to nine, 29% were ages 10 to 14, and 18% were ages 15 to 17.

In Rhode Island, between 2015 and 2019, 122,318 (59%) children under age 18 lived in married-couple households, 62,877 (30%) children lived in single parent households, and 17,915 (9%) children lived with relatives, including grandparents. A total of 3,512 (2%) children lived with foster families or other non-relative heads of household. There were 707 (<1 %) youth who were households or spouses.

Rhode Island's children are diverse in race, ethnicity, language, and country of origin. Mirroring the national trend, the Hispanic child population in Rhode Island has grown since 2000, both in numbers and as percentage of the child population. Hispanics make up 25% of children under age 18 in the United States and 25% of children under age 18 in Rhode Island. Between 2015 and 2019, there were 8,189 foreign-born children under the age of 18 living in Rhode Island, representing approximately 4% of the child population. Of Rhode Island children ages five to 17 % speak only English at home, 17% speak Spanish, 4% speak other Indo-European languages, 2% speak Asian or Pacific Island languages, and 1% speak other languages at home.

Sexual orientation and gender identity are other important facets of diversity among youth. According to the 2019 Youth Risk Behavior Survey, 11% of high school students in Rhode Island described themselves as lesbian, gay, or bisexual. This does not include students who responded, "not sure" (5%). Among high school students, 1.5% described themselves as transgender, and 0.9% said they were "not sure".

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 Assessment and Support Unit) 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 aids children and youth does 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.

Since 2018, The Department of Children Youth and Families issued the following statement on the Department's renewed focus on statewide prevention efforts, Pivot to Prevention. The goal of Pivot to Prevention is to affirm both internally and externally the Department's role and responsibility in prevention by outlining many of the strategies and actions we already undertake and where we will be enhancing efforts. This is our opportunity, to share our commitment to keeping children and youth safe in our communities through a prevention focus in five key areas:

- **Child and Youth Safety as Public Health Issue: Collaborating with sister agencies and community partners is analyzing and discussing our data and evaluation systems to maximize resources and strengthen our communities.**
- **Establishing a Stronger Network of Prevention** Creating a Behavioral Health strategic plan that includes a clear plan for equality in access to services, increased mentoring services, and the elimination of voluntary relinquishments; as well as improved the communications and rapid response to families in crisis.
- **Continuing to Ensure a Competent, Stable, Diverse and Accountable Workforce** Orienting our training and professional development for staff toward a health response, particularly social determinants of health, and increasing opportunities for advocacy for community health; training and hiring a diverse staff and to ensure professional grow.
- **Fiscal Soundness** Ensuring a robust process is in place for determining budget priorities and a plan that allows for shifts in funding to occur when priorities change; maximizing all opportunities for federal funding, implementing additional actions to leverage IV-E and Medicaid funding.
- **Effectiveness of Services** Completing our study of the Training School's effectiveness as an intervention including an analysis of long-term outcomes for youth who spend time at the Training School and in comparison, to youth who spend time in other types of community placements. Expanding our Active Contract Management process to all DCYF contracts.

Child Welfare

With the agency's continuation with focus on Pivot to Prevention, the Department has been assessing its practice as to how the agency responds to families in need but do not necessarily need ongoing services through the Department. Prior to the Pivot to Prevention, Rhode Island had a process to categorize reports that did not meet investigative criteria as Information Referrals. The Department developed and implemented Family Assessment Response (FAR). This preventative safety response addresses CPS reports that do not meet the criteria for investigation but contain risks and vulnerabilities. The FAR utilizes the Family Functional Assessment (FFA) tool (as described below) to assess the family's needs. The FAR process then allows for immediate access to home and community-based service options. Also, if a Child Protective Investigator conducts a FAR and determines that there is concern of abuse/neglect, the case can then transition to an investigation. By providing access to services to families through the FAR, families will have services in place to help keep their children safe.

Juvenile Corrections

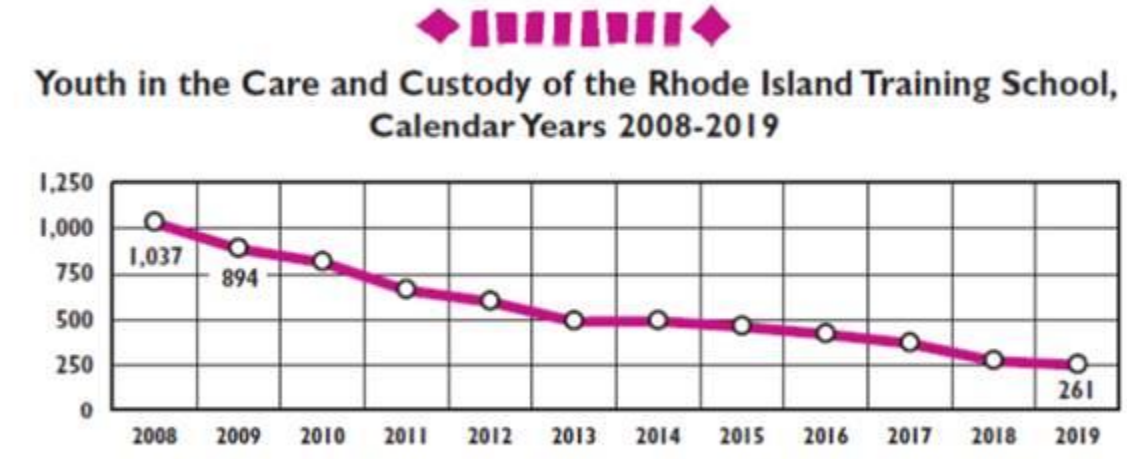
Transfers of Youth to JJ	2017	2018	2019	2020
# Opening to CW	5709	4738	3906	3300
# Transferring to JJ	27	21	17	13

DCYF is able to capture the three portals of entry reflective of whether a child has entered care through Child Welfare, Juvenile Corrections or through Children's Behavioral Health. These data fields in RICHIST allow the Department to track case activity of children and families as they move through the system. This mechanism quantifies the number of children and youth who are opened to the Department for abuse or neglect but are later linked with children's mental health services or juvenile corrections.

During FY 2020, our system shows that there were 3,300 youth being activated in our system with circumstances relating to child welfare, compared with 3,906 in 2019. Of that number, 13 were subsequently identified with juvenile justice involvement, compared with 17 last year. Any youth sent to the RI Training School for Youth (RITS) for less than 30 days would remain active on the FSU caseload. These data show a decrease in number of cases opening to child welfare and a decrease in the number of transfers to juvenile corrections in 2020.

Between 2008 and 2019, the annual total number of youths in the care and custody of the Training School at any point during the year declined by 75% from 1,037 to 261.8 Some of this decline is due to the cap that was placed on the population at the Training School in July 2008 of 148 boys and 12 girls on any given day.

The Rhode Island Department of Children, Youth and Families (DCYF) operates the Rhode Island Training School for Youth, the state's secure facility for adjudicated youth and youth in detention awaiting trial.



Source: Rhode Island Department of Children, Youth and Families, RICHIST, 2008-2019.

• A total of 261 youth (84% male and 16% female) were in the care or custody of the Training School at some point during 2019, down from 283 during 2018.
• On December 31, 2019, there were 73 youth in the care or custody of the Training School, 40 of whom were physically at the Training School.
• Of the 261 youth who were in the care or custody of the Training School at some point during 2019, 19% (50) were admitted at least twice in 2019, and 7% (17) were admitted three or more times.
• Of the youth discharged from the Training School in 2019, 56% stayed less than two weeks, 21% stayed two weeks to five months, 14% stayed six to eleven months, 8% stayed one to two years, and 2% stayed longer than two years.
• During 2019, the average age for youth at the Training School was 16 years. During 2019, there was one child age 11 or under held at the Training School, two children age 12, 47 youth ages 13 to 14, 132 youth ages 15 to 16, and 103 youth ages 17 to 18.

The Juvenile Hearing Board (JHB)

A Juvenile Hearing Board (JHB) is a community-based diversion program. Members of the JHB are community volunteer residents of the city or town. The goal is to divert youth arrested for lower-level offenses from Family Court, providing sanctions and referrals. Typically, JHB restorative justice meetings are 45 minutes, with a 15-30-minute follow-up 3 months later. The JHB has three goals: Restorative Justice, Prevention, and Community Investment.
There are active Juvenile Hearing Boards in 30 of RI's 39 cities and towns. JHBs hear about 400 cases per year across the state. The Rhode Island Justice Commission began JHBs in the 1980s by funding Coordinators. While those funds disappeared in the early 2000s, JHBs continued due to the dedication of their volunteers. RICJ began working with JHBs in 2009 and in recent years, FCCP/Family Care Community Partnership agencies have collaborated with JHBs to provide mental health services. JHB outcomes are positive with low re-arrest rates for youth. JHB objectives are:

- Reduce the number/percentage of juvenile cases referred to Family Court and ultimately reduce the number of system-involved youth in RI.
- Increase victim satisfaction and (if appropriate) potential involvement with youth offenders.
- Reduce the likelihood that juvenile offenders will commit future crimes.
- Improve competencies of youth offenders in areas such as school performance and behavior, family and peer relationships, anger management and other life skills.
- Increase awareness of issues relating to youth and families within the community.

The Juvenile Hearing Board (JHB) is designed to change the trajectory of a child's life who are otherwise exposed to the criminal justice system and diverts arrested juveniles from entering the justice system. The board members are appointed by the Mayor of each respective city and are composed of school staff, elected officials, and other community stakeholders. The JHB has been in operation for decades, however, this wasn't the case in Central Falls and Providence that were both reactivated with new members in Fall 2017. Now with the backing of the RI Department of Children, Youth, and Family (DCFY) and RI Community for Justice (RICJ). The JHB's of Pawtucket and Central Falls received funding from the Department to expand and capacity of the JHBs and improve services. The JHBs in both of these districts had been operating without any funding. Youth now have access to bus passes, driver's education classes, and mental health workers that will expedite wrap-around services for vulnerable families, while also

allocating resources to the training of JHBs members. With the support of DCYF and RICJ, the JHB has garnered resources to support and prevent recidivism.

Probation and Parole
According to the RI Kids Count book 2021 between 2008 and 2020, the annual total number of youths on probation during the year has declined by 70% from 1,624 to 493. A total of 493 youths were on probation during 2020, down 20% from 618 in 2019. Of the 493 youth on probation, 83% (408) were on probation at home, and 17% (85) were on probation in out-of-home placements.17,18,19,20
_ Some of the decreases in youth at the Training School and on probation from 2019 to 2020 were due to decreases in the number of offenses referred to Family Court, but the Department of Children, Youth and Families and Family Court also instituted procedures to reduce counts because of risks related to the COVID-19 pandemic probation are assigned to a probation worker in one of seven regional offices. The number of youths 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 youths on probation.

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 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 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. This Community services are being offered to youths and their families by the Family Community Care Partnership agencies covering the entire state of RI. During FY 2017, 253 youth received services from six community agencies.

Services for Transition Youth

John H. Chafee Foster Care Program for Successful Transition to Adulthood
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, 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 March 31, 2019, there are 1,308 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 helps 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. As of March 31,2019 there are 95 youth enrolled in the aftercare services.

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 March 31, 2019, there were 201 referred for life skills assessment and 121 youth completed life skills assessment and 41 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 connection undergoes a 5-hour mentor training and are supported for a minimum of a year. There are 108 active participants as of March 31,2019 of which 33% 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-homecare 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 March 31, 2019, ASPIRE participants have had the opportunity to participate in one-on-one financial coaching through the Super vitamin 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 March 31, 2019, there are 318 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.

Chafee Education and Training Voucher Program (ETV):

The Department of Children, Youth and Families (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 Education and Training Voucher (ETV) program.

Rhode Island continues to use ETV funding for youth who enter foster care on or after the youth's 16th birthday and up to the young adult's 21st birthday. At this time, Rhode Island is not opting to extend services beyond the young adult's 21st birthday except for ETV funding which will continue to be available to eligible participants until the academic year in which the young adult turns 23. Except for the information related to Pandemic Act funding provided below, we have not opted to extend ETV eligibility to age 26.

Our DCYF Higher Education Grant Program funding, usually an annual allocation of $200,000, can be used only for full-time students attending one of Rhode Island's three public higher education institutions. There is no per student cap on these state funds. In FFY 2020, fourteen (14) students received state funds totaling $123,389.

This year there were additional funding and temporary flexibilities for the Education and Training Voucher (ETV) Program. The Consolidated Appropriations Act (CAA)of 2021 was signed into law on 12/27/2020. This COVID-19 Relief package contains several important provisions for the child welfare system. The CAA Division X, titled Supporting Foster Youth and Families through the Pandemic Act (Pandemic Act) provided $50 million to be distributed to states in additional ETV funding and provided temporary flexibilities in the use of funding. This additional funding and flexibility allow the Department to assist youth whose was education disrupted due to the COVID-19 pandemic and public health emergency. It also requires states, through 9/30/21, to raise the maximum eligibility age to the 27th birthday. Through September 2022, the Pandemic Act allows states to increase the maximum allowable award amount to from $5,000 per year to $12,000 per youth per year but does not require states to give each eligible youth that amount. Under these provisions, the Chafee ETV vouchers may be used to maintain training and postsecondary education costs. The additional allocation to Rhode Island for FFY 2021 under the Pandemic Act is $257,651.00

For the 2020-2021 Academic Year, DCYF provided each student with funds to cover 100% of their unmet need unless they were eligible for the ETV funds only and reached their $5,000 annual federally mandated cap. For the 2020-2021, academic year, 30 youth attended school and received funding. Initially, this assistance totaled $269,168 from all funds [ETV - $145,779; DCYF Higher Education Funds - $123,389]. Initial ETV awards ranged from $1,000 - $5,000.00 and DCYF Higher Education Awards ranged from $2216 - $19,289. We anticipate our percentage for the 2021-2022, academic year to be between 80% - 100% of unmet need. However, we are now in the process of reviewing ETV awardees for the 2020-21 academic year to determine if they have remaining unmet need which may be covered in full or in part by the temporary annual per student cap of $12,000.

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, 247 active participants have been served as of March 31,2019.

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.

Voluntary Extension of Care

In June 2018, Governor Gina Raimondo signed into law the Voluntary Extension of Care Act, which authorizes the extension of Foster Care to age 21 using Title IV-E criteria. As a result of this new law, In July 2018 the department began its development of the Voluntary Extension of Care Services. The goal of the Voluntary Extension of Care (VEC) program is simple: support young people in becoming self-sufficient, independent, and thriving adults. The program is youth-driven with the young adult setting their own goals for housing, education, employment, and future success. DCYF's Youth Development Services (YDS) staff work with others to aid young adults who choose to participate in the VEC program with this transition and to provide access to other supports and services. As of May 2019, there had been 158 youth referrals ages 17-20, 28 youth had been assigned case management services and 35 qualified and signed into the VECA program. The rest of the youth will continue to be guided and connected with needed services.

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 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. For more information, please review the DCYF Behavioral Health Service Provider Guide.

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.

The division underwent a major transformation in response to new responsibilities for referrals, placement, and community services. Services are being provided to youth and families in accordance with the central referral unit in collaboration with services providers.

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.

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.

The CSBH unit has been working with families and youth as their need for residential placement have been explored successfully without the need for parents to relinquish their parental rights.

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.

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.

Child and Adolescent Needs and Strengths (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 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.

DCYF Early Childhood Initiatives

Building on prior work related to the developmental, social-emotional, and behavioral health needs of young children in the Rhode Island child welfare system, the department applied for and was awarded a 3-year $415,000 grant from the W.K. Kellogg foundation in Battle Creek, Michigan in the summer of 2017. This grant labeled as the "Rhode Island Getting to Kindergarten Initiative" has a primary focus of supporting the development of policies and practices that help meet the need of the youngest and most vulnerable young children in our system. The goals of the grant include:

Increasing the rate of developmental screening and access to supportive services for children birth to 5 in the RI Child Welfare System.

Increasing access to High Quality Early Care and Education for children birth to 5 in foster care.

Implement training for child welfare and early childhood service delivery staff to better meet the needs of young children in the child welfare system.

Integrated into the goal one of this grant initiative is a focus on increasing access to developmental screening and evaluation for children are birth to 3 who are identified as victims in indicated cases of abuse/neglect. The most recent revision in policy has resulted in an average referral rate of over 90% for 18 consecutive months since September 2017 for this birth to 3 population. DCYF anticipates that this rate of referral will be sustainable and has assembled a cross-system workgroup to track rates of engagement and screening for this population. Over the course of the 3-year grant DCYF in partnership with RI Department of Health will develop an electronic referral and tracking system to support access to supportive services. 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 past year baseline data has been gathered and a goal has been established to ensure that over 50% of children 3 to 5 years old in DCYF care will be successfully screened in year two of the grant and the rate of successful screening will increase to 75% by the fall of 2020.

RI DCYF has continued to promote and refer families with young children to federally funded MIECHV 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: 93 in 2016, 105 in 2017 and 117 in 2018. 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. RI 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. As part of the Rhode Island Getting to Kindergarten Grant the department has convened a cross-system workgroup that meets monthly to support access to High-Quality Early Care and Education services for children in foster care. Over the course of the grant 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.

The department has also focused on training and workforce development as a part of the Rhode Island Getting to Kindergarten Initiative to support the child welfare and early childhood service provider communities on topic of infant mental health practice for children in the child welfare system. RI DCYF has developed a partnership with the Rhode Island Infant Mental Health Association to deliver training and technical assistance to DCYF staff over the course of the 3-year grant. The goal of this effort is to increase knowledge gain and collaboration across system to better serve the needs of infants and toddlers in the RI child welfare system. To date one full day conference has been held where DCYF staff and community providers received content related to trauma informed practice and relationship based infant mental health practice, Over the next year DCYF will work with the RI Infant Mental Health Association to bring together a small practice group of participants from this initial full day conference to support ongoing evolution of infant mental health practice in the context of child welfare services. Future trainings will be available to DCYF staff over the next 18 months to support this ongoing work.

Neo-Natal Abstinence Syndrome Task Force

The Neonatal Abstinence Syndrome Task Force has continued to focus attention on the needs of substance exposed newborn population involved with the department. With the rates of opiate abuse on the rise both nationally and here in Rhode Island the NAS Task Force has continued to work 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 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. This task force has been central to the development of protocols related to Plans of Safe Care that is mandated by recent CARA legislation. 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. RI DCYF has also reinstituted a Substance Use Disorder Liaison position and this staff person has become actively involved in the NAS Task Force work. RI DCYF has continued to utilize revisions to data systems within RICHIST that track substance exposed newborns and specifically infants diagnosed with NAS. This has allowed for better tracking of needs and services referral processes for this critical population. In 2018, RI Governor signed an executive order urging the state agencies to provide comprehensive mental health and substance abuse treatment to the most vulnerable population.

In accordance with federal laws Child Abuse and Prevention Treatment Act (CAPTA, Pub. Law 93-247) and Comprehensive Addiction and Recovery Act (CARA, Pub. Law 114-198), and Rhode Island General Laws § § 40-11-2, 40-11-6, 40-11-7, 42-72-8, the Department of Children, Youth and Families (hereinafter the DCYF) must identify infants at risk of child abuse and neglect as a result of prenatal substance exposure, ensure that a Plan of Safe Care (POSC) is developed for these infants, and ensure the referral of these infants and affected caregivers to appropriate services.

All substance exposed newborns must have a Plan of Safe Care (POSC) at the time of discharge from the birth hospital. Plans of Safe Care are developed at discharge by addressing supports in place for the health needs of the newborn, and substance use disorder treatment needs of the parent and/or caregiver. POSC may include services such as home visitation, early intervention services, and recovery supports.
Since July 1, 2018 there have been 253 referrals made had been made and 128 Plans of safe care had been received at the RI Department of Health. The Department of Children Youth and Families will continue to follow the Pivot to Prevention plan in order to assist the families and their children in RI.

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. According to the 2019 RI Kids Count Book in RI 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. Black non-Hispanic children (45%), and Hispanic Children (39.7%) who experience out-of-home placement were placed in congregate care as their first placement more often to

their white peers. For more information, please see the DCYF Permanency Report, July 1, 2012 – June 30, 2017.

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, as well to the children and youth who identify as part of the LGBQ community. DCYF diversity council collaborates with Youth Pride to provide education and training to the DCYF staff as need. Youth Pride has a very strong present in RI and served as clearing house and training for the LGBTQ community in RI.

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, commercial sexual exploitation of children and the Psychiatric Rehabilitation Treatment Facility, which the Department is currently in the process of finalizing the last steps 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. The Department continue to practice the Active Contact Management process which had been proven to strengthening the relationship with providers and enhance the capacity to a more empower model that has the potential of producing better results for children and families which focus on outcomes and accountability.

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. To do so, DCYF is working on developing a process that would result in providers being able to direct bill.

In the past, some services provided by DCYF were not available to children and youth unless they were opened to DCYF. DCYF is currently servicing families and their children that needs behavioral Health services regardless if they are open to DCYF. The Department had been managing those cases in providing wrap around supportive services to those family and connecting them with sustainable behavioral health connections.

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. The CANS assessment is being utilized across the Department in Foster care and in-Home Services. 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.

Starting in FFY2020, DCYF will be the lead state agency on Kid's Link, a hotline that provides information to clients, families, and providers regarding children's behavioral health. This service was supported by RIDOH through youth suicide prevention funding that will expire September 30, 2019.

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 the 2019 Rhode Island Kids Count Factbook In State Fiscal Year (SFY) 2018, 27% (33,407) of children under age 19 enrolled in Medicaid/Rite Care had a mental health diagnosis. Of the children with mental health diagnosis 21% were ages 6 and under, 37% were ages seven to 12, and 42% were ages 13 to 18. In addition, 42% were females and 58% were males.

In SFY 2018, 1,486 children under the age 19 enrolled in Medicaid/Rite Care were hospitalized due to a mental health related condition (up from 983 in SFY 2016), and 2,649 children had a mental health related emergency department visit (up from 1,690 in SFY 2016, a 57% increase). Eighty-seven percent of those mental health related emergency visits did not result in a hospitalization.

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 (CMHCs) have the 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 Rite Care 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, psychiatric residential treatment facilities, residential counseling centers, group homes 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 process 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 two Assessment and Stabilization placement with the capacity of 16 slots available across the state for children and youth from 12 to 18 years of age. These are temporary placements that provide both social and mental health services to children and youth.

Adolescent Male
There are 5 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 5 group homes have a capacity of 38 youth.

Adolescent Female
There are 6 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 6 group homes is 38.

Under 14 Group Homes
There are 2 group homes with a capacity of 12 children.

RTC (Residential Treatment Center)
These residential treatment center 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 including Psychiatric Residential Treatment Facilities, RTC Children, RTC Juvenile Justice, and RTC Developmental Delay. There are 12 programs with a capacity of 111.

Problem Sexual Behavior (PSB) Group Homes
There are 2 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 2 group homes is 16.

Developmental Disabilities
There are 3 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 7 specialized programs for semi-independent with a capacity of 39 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 68 Independent Living slots 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.

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.

According to the Rhode Island Kids Count Factbook 2019, as of December 31,2018, there were 2,199 children under age 21 in the care of DCYF who were in out-of-home placements. Older youth are more likely to be place in congregate care settings (e.g., group homes, residential facilities) than young children. FY 2018, 302 of the children and youth in out-of-home placement were in group homes or residential facilities.

The Department continues to seek efforts to increase use of foster care and to continue to reduce the unnecessary use of congregate care placement. One of the major efforts the Department had completed a full weekend retreat with the purposed of increase the number foster parents. In March 2018 DCYF hosted 74 prospective foster families to a full weekend of training, discussions, with the support of local and state government agencies and community partners. As of February 2019, 83 families are fully licensed, 70 are in the process of being licensing and we estimated around 100 placements have been identified. The Department will continue to explore different avenues along with the support and collaboration of our sister agencies and community partners to seek permanency and wellbeing for children in state care.

Other Clinical and Prevention Services through DCYF

Evidence Based Practices, Evidence Informed, Community Based Services
Because of the large-scale re-procurement in FY 2018, 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, 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 five 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 support 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:

FCCP	FY 2020
Total families served*	1472
# DCYF Referrals	740
# Community Referrals	732
Source: RIFIS QA Report *Unduplicated count of referrals by primary child RIFIS ID	

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.

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 28 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.

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 have 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. The Department continues to collaborate with the process for referrals from DCYF to adult services provided by BHDDH. As of June 2019, there were 77 youth age 18 to 21 being referred for both BH and DD.

Special Population: Commercial Sexual Exploitation of Children (CSEC)

As of June 30th, 2021, 1308 children in congregate care were screened using the CSEC Screening Tool (including children who were rescreened two or more times),
74% (N=970) were screened with No Identified Level of Risk
11% (N=137) were screened as 'At Risk' youth
9% (N=117) were screened as 'High Risk' youth
6% (N=82) were screened as 'Confirmed victims'

The implementation of the screening tool within congregate care facilities has resulted in allowing youth who go AWOL, or have previous AWOL history, to be identified earlier and an understanding of the concern of human trafficking risk to be mitigated quicker by the Human Trafficking Coordinator. The Human Trafficking Coordinator works closely with the group home providers and populations providing services to the children identified as High Risk or confirmed, due to the screening tool results identifying victims as a faster rate. The screening tool has provided the Human Trafficking Coordinator with data in order to better identify potential victims.

- Residential Treatment Centers had the greatest proportion of youth identified as 'High Risk' (31%) and 'At Risk' (39%). Group Homes had the greatest proportion of youth identified as 'Confirmed victims' (44%).

- Of the youth in congregate care screened for CSEC, 45% were identified to have a history of multiple absences from home or placement, 13% of youth were identified with having exposure to pornographic material, 12% of youth were identified with themselves or someone else having sexually explicit photo/video of them, 11% of youth were identified with having a sexual or romantic relationship with an older partner, and 11% of youth were identified with use of one or more substances. Female youth

predominantly made up the greatest proportion of each At Risk characteristic except for disclosed, suspected, or reported gang affiliation and use of one or more substances which had a greater proportion of male youth.

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.

Differentiation 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, RIDOH, 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 childcare 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.

System of Care Grant Proposal

The Rhode Island Executive Office of Health and Human Services submitted a System of Care Expansion and Sustainability Grant request in February 2021 for $8,891,325 over four years to support our work to strengthen Rhode Island's system of care for children experience behavioral health crises. The impact of COVID-19, our state's opioid crisis, and ongoing economic difficulties create challenges for our families that affect our state's children - heightening the need for a unified system of care. In response, we are implementing the Rhode Island Children's Behavioral Health System of Care (RICSOC).

The purpose of Rhode Island's system of care expansion and sustainability efforts will be to build on previous efforts and will improve access and services for children and youth experience behavioral health crises. The population of focus is a diverse range of 1075 children and youth, birth through age 21, with, or at risk of, serious emotional disturbance (SED), first episode psychosis (FEP), or substance use disorder

(SUD). Because of Rhode Island's small size, our strategic plans reflect our commitment to strengthening our entire statewide system of care, to serve all children experience behavioral health crises. For purposes of this grant, we will begin with Providence and Woonsocket as the two local jurisdictions of focus and continue to build out statewide.

To strengthen our system of care and streamline services, Rhode Island shall pursue procurement and implementation of a Single Point of Access for children's behavioral health services with 24/7/365 availability and capacity to screen, triage, and initiative referrals to appropriate services and supports. To meet the urgent needs of families that will contact the Single Point of Access for their children experience a behavioral health crisis, or being at risk for one, Rhode Island will expand statewide 24/7 emergency services through a trauma-informed Mobile Response and Stabilization Service (MRSS) model. MRSS addresses youth and family needs and stabilizes their circumstances, which can prevent the need for a higher intensity intervention or additional system involvement. And to help behavioral health providers address the Social Determinants of Health, RICSOC will participate in the state's current procurement of statewide referral management software, to build a coordinated network of health and social service providers in Rhode Island.

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 disorder and/or a developmental disability by maintaining a system of high quality, safe, affordable and coordinated care across a full continuum of services. Through prevention, early intervention, treatment and recovery support, BHDDH promotes the health, safety and well-being of all Rhode Islanders by developing policies and programs that address developmental disabilities, mental illness, addiction, recovery and community support. Our 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, BHDDH is a champion of the people we serve, addressing their needs in a timely, efficient and effective manner. BHDDH is comprised of three large Divisions and Central Management:

Central Management
In 2019, several units within the Division of Behavioral Healthcare moved to Central Management.

Public Affairs
The Policy and Planning Unit joined with the Communications Unit to create the new Public Affairs Unit. Public Affairs leads the development of plans, roadmaps, policies and procedures to guide and align the mission and vision of the Department 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.

Finance

Most financial matters for the Department are processed through Central Management. These include: procurements, payments, and contracts. Fiscal management of grants remained in the Division of Behavioral Healthcare.

Human Resources
Human Resources handles the hiring of candidates, manages benefits, and provides resources to current staff. Applicants to new positions apply to all Rhode Island state postings in one place and applicant managers can review and select candidates via the NeoGov system.

Legal
Our Legal department consults on all Division of Behavioral Healthcare contracts developed through our agency as well as work with Developmental Disabilities on special cases or on cases in transition. In cases on contract cancellation, our Legal team is also consulted to ensure we're following the terms of contractual obligations.

Licensing
The Office of Facilities and Program Standards and Licensure licenses programs that provide services to individuals who are developmentally disabled, cognitively disabled, mentally ill or individuals who have substance use or substance dependence disorders. This Office processes licenses for organizations that provide Behavioral Healthcare Services, Services for Persons with Developmental Disabilities, and Services for persons with Cognitive Disabilities. Organizations are issued an 'umbrella' agency license and additional site-specific licenses. The licensure period is for two years. The Licensing Office does not process professional licenses for an individual including: Licensed Independent Social Worker, Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, Licensed Chemical Dependency Clinical Supervisor, and Licensed Chemical Dependency Professionals. They are the responsibility of the RI Department of Health. For more information on these licenses, contact the Department of Health at 222-5960 or visit www.health.ri.gov.

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 (ESH) 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.

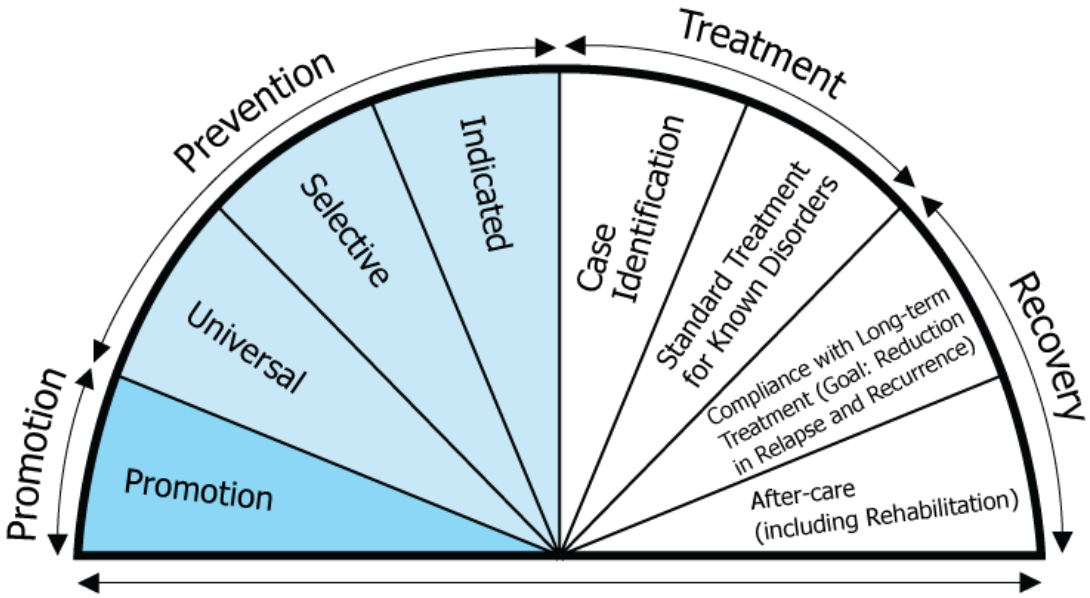
The Division provides a comprehensive approach to attainment of six overarching goals. These goals are consistent with those of SAMHSA's National Behavioral Health Quality Framework and include:

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
Recovery Community Centers
Community Integration Services
Supported Housing Services
Supportive Employment Services
Outpatient Detoxification Services
Medical Detoxification Services
Opioid Treatment Programs
Residential Services
Individual and Placement Services (ISP)
Chronic Illness Management
Peer Recovery Specialist
Mobile Crisis Intervention

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.
RI has an integrated (substance use disorder and mental health) approach to training and certification of PRSs. We are rapidly increasing our workforce and recently formalized our system for training supervisors of PRSs. Beginning in December 2018, Peer Based Recovery Support Services (PBRSS) are Medicaid reimbursable in RI. Reimbursement is for both 1:1 services and groups utilizing BHDDH approved evidence-based practices. Providers must first be Certified by BHDDH to provide PBRSS before they can enroll in Medicaid for this service.

The University of Rhode Island has been studying the efficacy of RI Peer Recovery Specialist infrastructure. Focus groups of current PRS and those in the process of becoming PRS have informed the process. A final report of this study will be completed 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 71 licensed providers, licenses 16 different services, and issues 797 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. BHDDH has seen a decrease in licensed services since services from developmental disability organizations are no longer licensed but instead certified under the agency license.

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.

Services for clients with serious and persistent mental illness in RI are provided in specified geographic areas through Community Mental Health Centers (CBHCs) that have been previously designated and established the Director of the Department. There are six CBHCs in RI serving eight designated geographic/catchment areas. Unlike some states, RI's behavioral healthcare system does not operate within a county structure. BHDDH licenses 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 mental illness and severe and persistent mental illness. BHDDH administers a system of care that provides treatment and recovery supports to over 44,000 Rhode Islanders in CY2020, which is about 4% of the total RI population.

Of the 36,094 individuals over the age of 18 served by the public mental health system, 23,275 received mental health services and 15,222 received substance abuse services; and of the individuals under the age of 18, 204 individuals received substance abuse services.

BHDDH's system of care consists of 36 licensed providers with 102 service sites. Six of the licensed providers are CBHOs, 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).

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

Mobile Crisis Infrastructure

In March 2021, BHDDH conducted a request for information (RFI) for interested parties to provide input on implementation of a crisis system consistent with the core elements described in SAMHSA's National Guidelines for Crisis Care. BHDDH received 9 responses to the RFI. The major themes from responses and recommendations for structuring the Crisis System:

- Community Level Coordination/Collaboratives
- Single behavioral health management entity that can braid funding
- Single point of access (air traffic control model) for GPS enabled call center hub to include 988, real time bed registry and dispatch of mobile teams
- All CCBHCs should provide facility-based crisis services
- Expand walk in/drop off locations to 4 with 23 hour stabilization
- Community based service continuum with access to statewide services when needed
- Create common regulations and data systems across state agencies

Importantly, two significant developments in policy surrounding behavioral health crisis services will have significant impact on the evolution of these services in Rhode Island.

- Continued adoption of the Certified Community Behavioral Health Clinic (CCBHCs) model. According to the National Council for Behavioral Health, CCBHCs are "designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals." CCBHCs are responsible for providing nine types of services, including 24/7 behavioral health crisis care.
- Passage of the National Suicide Hotline Designation Act. The passage of this legislation at the federal level requires that by July 16, 2022 all states make "988" the universal number to access their state's Suicide Hotline. The legislation also explicitly allows the state to assess a fee on all phone lines to support both the crisis line infrastructure and mobile crisis treatment.

In light of these developments, the State sought comments on how it can better integrate behavioral health crisis programming within the behavioral healthcare system. Crisis services are a critical component of a broader behavioral healthcare system, and crisis services must work cooperatively with behavioral health service providers of different types (including community mental health centers, hospitals, substance use treatment providers, residential programs, detoxification programs, and crisis stabilization units) to ensure delivery of effective, person-centered interventions.

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 and ACT 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).

BH Link is a program to support individuals in crisis for behavioral health issues through telephone hotlines, mobile outreach and a dedicated behavioral-health, community-based facility that provides a short-term alternative to emergency department triage that links people to treatment in the community. The triage center is located in East Providence, RI and opened in November 2018. As of July 27, 2021, there has been a total of 4,646 face-to-face assessments at the triage center and a total of 19,848 calls to the hotline, 414-LINK. 345 naloxone kits were also distributed at the triage center to date.

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 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 provides clients with access to 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.

Residential Programs:

Mental Health Psychiatric Rehabilitative Residences, also known as residential services, 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. They 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.

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 MHOs 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 frequently planned with the RI Substance Use and Mental Health Leadership Council(SUMHLC), the Department's training and technical assistance provider, to assist CMHCs 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 to 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 (RIDOH) 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 RIDOH'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. The Department runs a State Youth Treatment Implementation grant to help youth and young adults ages 12-25 who have substance use disorders or co-occurring substance use and serious emotional disorders; identify needs and gaps in the system and develop plans to address the needs. The plans include services, funding and workforce development. BHDDH is in the middle of implementing Seven Challenges in 4 operating sites, including private practice clinicians.

The current system includes:

- Outpatient programs that are operated by hospitals and licensed behavioral healthcare organizations
- 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. Peer recovery supports have been approved by CMS as a billable Medicaid service. 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 and parenting women and women who deliver substance exposed newborns, and 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 institutional care.

Criterion 2: Mental Health System Epidemiology: The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) administers a behavioral health system of care that provides treatment and recovery supports to over 44,000 Rhode Islanders in CY2020, which is about 4% of the total RI population. BHDDH's system of care consists of 36 licensed providers with 102 service sites.

Of the 36,094 individuals over the age of 18 served by the public mental health system, 23,275 received mental health services and 15,222 received substance abuse services; and of the individuals under the age of 18, 204 individuals received substance abuse services.

In CY2020, about 8,638 individuals over age 18 served by Rhode Island's BHDDH-licensed community mental health centers (CMHC) received Integrated Health Home services, while 1,729 received the higher acuity services under the Assertive Community Treatment program. The remaining 15,881 individuals were served in general outpatient.

In CY2020, there were 7,374 individuals over age 18 receiving substance abuse services under the Medication Assisted Treatment and/or 3,716 receiving Opioid Treatment Program Health Home services (OTP-HH). In CY2020, BHDDH served 1,204 individuals who identified as Veterans or active military, although the status of about 10% 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 contracts directly with community providers. Services are provided to children and youth involved with DCYF. DCYF has several programs and services for children and families not involved with DCYF that provide diversionary and preventative support and services to promote wellness, including Kid's Link.

Criterion 4: Targeted Services to Rural and Homeless Populations and Older Adults:

The Rhode Island Continuum of Care assists individuals and families experiencing homelessness or those at-risk of homelessness and provides the housing and support services needed to rapidly and permanently end their homelessness and maintain stable housing. The Continuum of Care program promotes community-wide planning and strategic use of resources to: address homelessness; improve coordination and integration with mainstream resources and other programs targeted to people at risk of or experiencing homelessness; and improve data collection and performance measurement that allows each community to tailor its program to it strengths and challenges. Representatives of relevant organizations within a geographic area establish a Continuum of Care to carry out the responsibilities set forth in the US Department of Housing and Urban Development (HUD) Continuum of Care Program Interim Rule.
In 2009 the HEARTH Act (Homeless Emergency Assistance and Rapid Transition to Housing) was passed by Congress and substantially changed homeless assistance policy. The HEARTH Act required, among other things, the development of a Continuum of Care governance structure to achieve substantive outcomes.

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

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

The RICoC promotes the HUD goals through a Coordinated Intake and Assessment process, utilizing a Housing First Model. The RICoC consists of a Board of Directors, a membership group, and 6 standing committees (System Performance & Planning, Recipient Approval & Evaluation, Veterans, Families & Youth, Chronically Homeless/High Needs Individuals and HMIS). In accordance with HUD regulations (24 CFR Part 578), representatives from relevant organizations that serve homeless and formerly homeless individuals and other interested, relevant organizations within the State of Rhode Island have established a Continuum of Care to carry out the duties assigned in the regulations.

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

BHDDH 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. This grant concluded in 2019.

Older Adults: Rhode Island's Elder Mental Health Advocacy Coalition (RIEMHAC) meets monthly to identify programmatic and policy needs in the community, including 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

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 four staff; an Associate Director and 3 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 3 Block Grant staff responsible for data collection, uploading to the federal system and assisting the Department, including the Block Grant team, in implementing data-based decisions and is in the process of hire additional staff to assist with their expanded role under Central Management.

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 mental health services and substance use disorders (all ages) 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.

10% ESMI Mental Health Set Aside: For the next two-year cycle, the Block Grant set aside is being used to pilot a modified coordinated specialty care program focusing on individuals experiencing first episode psychosis in a racially diverse area containing the cities of Central Falls and Pawtucket through Gateway Healthcare. To ensure the funding level is like other discretionary grant-funded sites, it will also

be supported by the required 10% set aside for FEP on both COVID-19 supplements (NOAs 1B09SM083964-01 and 1B09SM085342-01).

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. Community Care Alliance and Thrive, who were both funded by the first Healthy Transitions grant still operates today. In 2020, Rhode Island added The Providence Center and Newport Mental Health as two new sites delivering these services.

RI Healthy Transitions features a modified version of the evidence-based practice, Coordinated Specialty Care (CSC), to provide developmentally appropriate services to youth and young adults 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, and Dissociated Identity Disorder.

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.

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 (RIDOH). 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 women in recovery; 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 intensive 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 effects of mental health and substance use disorders on pregnancy and post-partum. The programs include childcare services for clients with children. **The Paradigm Program** through Blackstone Behavioral Health offers an Intensive outpatient program for women with cooccurring disorders**.**

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

The state has a comprehensive **Domestic Violence service** system as well as a system for Victims of Sex Trafficking that provides clinical services, s safe 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 and sex trafficking advocates work closely with DCYF and the courts; advocates are co-located in the Child Protection unit and are available victims and to the statewide Family Care Community Partnership agencies which serve families with children under age 18 (up to 21 years old, in certain cases) with behavior issues, juvenile delinquency or other problems that place them at risk of involvement with the Rhode Island Department of Children, Youth and Families (DCYF).

Criterion 4: **Persons Who Inject Drugs** (PWID) Licensed behavioral health organizations are required to provide access to treatment within 14-120 days of the request for services. All agencies most contract BHDDH within 7 days of reaching 90% of its treatment capacity. The program must admit each person who requests services and needs treatment for intravenous drug misuse no later than 14 days after making the request or within 120 days of the request if the program has no capacity to admit the individual, the program must make interim services available within 48 hours, and the program must offer the interim services until the individual is admitted to a substance abuse treatment program. The Department monitors the waiting lists to ensure access to services and partners with the RIDOH to provide linkages to the Education, Needle exchange, Counseling, Outreach, Referral (ENCOR) program for HIV and other blood borne pathogens prevention and intervention for people who inject drugs.
The interim services should include, counseling and education about HIV and TB, the risks of needle sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur. Referral for HIV and TB treatment services, if necessary; counseling pregnant women on the effects of alcohol and other drug use on the fetus of prenatal care for pregnant women. Each program has an established waiting list that includes a unique patient identifier for each person who injects drugs seeking treatment, including patients receiving interim services while awaiting Admission. The program must have a mechanism that enables it to maintain contact with individuals awaiting admission; consults with the Stare's capacity management system to ensure that 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 20 confirmed cases of active TB in 2018, up from 13 in 2017. Data is publicly available on the Rhode Island Department of Health website, with 2019 data becoming available in October 2021.

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. Through Ryan White funds, a physician specializing in HIV/AIDs has been in place for several years.

Criterion 7: **Group Homes for Persons in Recovery from Substance Use Disorder:** Currently, recovery housing is funded through discretionary grants (SOR and Opioid Stewardship). The Department is currently working on implementing a tiered system for payments. The first three months are 100% reimbursable, the next three months are 75% reimbursable, and the following three months are 50% reimbursable. About 479 beds are licensed by BHDDH in recovery housing.

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 and Women with Dependent Children

1. The program must prominently display the Department's pregnant women as priority for admission poster in their facilities, where visible to patients
2. 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.
3. The program makes interim services available within 48 hours to pregnant women who cannot be admitted because of lack of capacity.
4. The program gives preference in admission to pregnant women who seek or are referred for and would benefit from treatment services.

5. 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
6. When appropriate, the program must offer 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. This also includes education about prenatal and pediatric care, medication assisted treatment services, and risk of substance use for fetuses in utero.
    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.
7. Program must make continuing education available in substance use disorder treatment and prevention services to any employee who provide services.
8. The program must provide or arrange for: primary medical care, including prenatal care; referrals to prenatal care and counseling
9. The program must have a system in place to protect patient records from inappropriate disclosure and the systems complies with all applicable state and federal laws and regulations including 42 CFR, part 2. and include provisions for employee education on confidentiality requirements and the fact that disciplinary action may occur upon inappropriate disclosure.

Persons Who Inject Drugs

1. Within 7 days of reaching 90% of its treatment capacity, the program notifies the State whenever it reaches 90% of its treatment capacity.
2. The program admits everyone who requests and needs treatment for intravenous drug abuse:
    a. A. Not later than 14 days after making the request or
    b. Within 120 days of the request if the program has no capacity to admit the individual, the program makes interim services available within 48 hours, and the program offers the interim services until the individual is admitted to a substance abuse treatment program.
3. When appropriate, the program offers interim services that include, at a minimum, the following:
    a. A. Counseling and education about HIV and TB, the risks of needle sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occurs.
    b. Referral for HIV and TB treatment services, if necessary
    c. Counseling pregnant women on the effects of alcohol and other drug use on the fetus of prenatal care for pregnant women,

4. The program established a waiting list that includes a unique patient identifier for each injecting drug abuser seeking treatment, including patients receiving interim services while awaiting Admission.
5. The program has a mechanism that enables it to maintain contact with individuals awaiting admission; consults with the Stare's capacity management system to ensure that 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.

1. Appropriate HIV/AIDS pre-and-posttest counseling.
2. 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.
3. Therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease.
4. 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.
5. 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.

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. This continues to be a contract deliverable of the Substance Use Mental Health Leadership Council despite being suspended for a time during 2020 due to safety concerns around the COVID-19 pandemic.

Criterion 10: Professional Development:

Substance Use Mental Health Leadership Council (SUMHLC) The Department provides training and technical assistance to the Behavioral Health Organizations (BHO) on an ongoing basis. Currently, this contract is with the Substance Use and Mental Health Leadership Council (SUMHLC), the trade association for the mental health and substance use disorder treatment providers. Past trainings included 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, smoking and vaping. In 2011 and again in 2015, BHDDH developed and funded the Rhode Island Prevention Resource Center (RIPRC) with Prevention Block Grant funds for 5-year increments. Discretionary funds from PFS 2018 and SOR grants also go to the RIPRC to develop substance-specific (alcohol for PFS 2018; opioids for SOR) training and technical assistance as needed.

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, 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 had a statewide network of community-based substance abuse prevention coalitions, called Task Forces. The state's 32 Task Forces were 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 until 2016.

In 2016, the Department decided to revamp the prevention delivery system by creating regional prevention task forces. 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 prevention priorities throughout the state. Each of the Regional Prevention Task Force coalitions (RPTF) have completed a needs assessment and regional work plan which describes 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 draws information from a set of municipal needs and resource assessments which creates a set of regional priority needs. Each municipality had the ability to select 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 Task Force coalitions (RPTFs) 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), the Prevention Technology Transfer Center (PTTC) 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 Opioid Response grant, including programming to award mini grants to communities through the region to reduce opioid misuse. The Regional Prevention Coalitions have implemented Project Lazarus, a comprehensive community approach to reduce opioid overdose and prescription drug misuse. The Regional Prevention Coalitions implemented 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 has been 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.

Rhode Island was awarded the **Strategic Prevention Framework Partnership for Success 2018** grant in the fall of 2018 which expands on this work by focusing on expanding underage drinking prevention in twenty communities and to youth and young adults between the ages of 12 and 20 years old. The State Epidemiological Outcomes Workgroup and Evidence-Based Practices Workgroup are continuing as subcommittees attached to the new PFS 2018 grant. This grant funds 20 high-need municipalities through the regional structure.

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 47 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 and again in 2015, BHDDH developed and funded the Rhode Island Prevention Resource Center (RIPRC) for 5 -year increments 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%)

Rhode Island General Law identifies the Rhode Island the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) as the State entity responsible for oversight and coordination of the State's program to prevent the sale or distribution of tobacco products to underage youth under the age of 21.

Synar: As the designated state agency responsible for tobacco compliance, BHDDH conducts the annual SYNAR statewide survey, a random of retail tobacco outlets to determine retailer compliance with the state statute as required by SAMHSA. An annual Synar report of survey results is submitted by the end of the calendar year with a requirement the Rhode Island meet 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.

FDA: BHDDH has been designated Rhode Island's FDA State Tobacco Compliance Check Inspection Program contractor since 2011 conducting advertising and labeling and undercover buy compliance check inspections. This program addresses regulations in two areas. First, regulation of advertising, marketing and promotion of cigarettes, smokeless tobacco products and ENDS products. Second, restricts the sale of cigarettes, smokeless tobacco, ENDS products and newly deemed products to minors under the age of 21 years old. Conducting an average of 1,300 inspections per year, 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.

Current 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.

Healthy Transitions: Healthy Transitions RI is in the process of its second discretionary grant. The grant addresses the needs of 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, Providence and Newport, 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. The sites previously started in Warwick and Woonsocket continue to operate after the first Healthy Transitions grant closed in 2020.

Partnership for Success 2018 (PFS 2018): The Rhode Island Strategic Prevention Framework Partnerships for Success (PFS) project provides funds to twenty high-need communities to address underage drinking efforts with youth and young adults ages 12-20. 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.

Screening, Brief Intervention and Referral to Treatment (SBIRT): Rhode Island SBIRT will pre-screen 15,000 individuals over a five-year period; approximately 1,000 in year 1 and 3,500 in years 2-5. The screening will cover tobacco, alcohol, marijuana and other drugs. Screenings will take place in primary care/health centers, urgent care centers, emergency departments, through community health teams, and at the Department of Corrections. This initiative complements the State's efforts to integrate physical and behavioral healthcare. This grant expires September 30, 2021, and there are current initiatives in place to create a manual for sustaining this practice post-funding. Using a recent evaluation supplement, a guidebook with workflows and helpful hints was created based on provider feedback to help new sites start SBIRT in practices across primary care and other healthcare facilities.

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. It is currently awaiting news of a requested no-cost extension as of August 2021.

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

State Opioid Response (SOR): The Rhode Island State Opioid Response (RI-SOR) grant is designed to 1) reduce the number of prescription drug/opioid overdose-related deaths and adverse events among individuals 18 years of age and older, 2) increase access to treatment and reduce unmet needs through the provision of prevention, treatment, and recovery activities, and 3) support a comprehensive response using epidemiological data in the planning process. Data collected via the GPRA and other internal measures will help identify any gaps in the continuum of care and inform future expansion and evolution of these activities. The overarching goals of these initiatives are: 1) to increase access to medication assisted treatment, 2) increase access to treatment and recovery support services in the community, and 3) increase the capacity of the community to assess, plan, and implement strategies to prevent substance/opioid misuse.

988 Planning Grant: In July 2022, 988 will become the national three-digit dialing code for the National Suicide Prevention Lifeline, replacing the current phone number of 1-800-283-TALK (8255). As the administrator of the Lifeline since its inception in 2005, Vibrant Emotional Health knows that a national three-digit phone number can improve access to vital crisis services, improve the efficacy of suicide prevention efforts, and reduce the stigma about mental health and getting help. These grant funds will help Rhode Island develop a clear roadmap for how they will address coordination, capacity, funding, and communication strategies to establishing 988.

Early Diversion: In September 2020, Rhode Island received a SAMSHA early diversion grant for the purposes of improving partnerships and policies that support law enforcement's response to individuals with mental illness and co-occurring disorders in times of crisis. To do this, Crisis Intervention Training (CIT) is being implemented across the state while a statewide implementation plan is being developed. Furthermore, it is a goal of this grant to increase the healthcare referrals of person with mental illness and/or co-occurring disorders that are encountered by police to our state's assessment and triage center, BH Link. As part of this project, a law enforcement liaison helps engage police departments to refer to BH Link and take the One Mind pledge.

Summary of General Strengths and Needs of the System

The Rhode Island Behavioral Healthcare system has several 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 RIDOH), 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). New this past year was also the Children's System of Care workgroup with EOHHS and DCYF taking the lead.
3. BHDDH has reorganized its Division of Behavioral Healthcare to integrate mental health, substance use disorder and prevention across units.
4. BHDDH has reorganized, moving several units under Central Management, in order to better collaborate between Divisions.
5. 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.
6. BHDDH has strengthened its capacity to apply for and evaluate federal discretionary grants to pilot innovations in the field of MH, SUD and prevention.
7. Close collaborations and relationships with other agencies, programs, and Departments which is improving the Department's ability to serve pregnant and parenting women with substance use disorder sand their children.
8. A coordinated system of regional prevention task forces that provide evidence-based interventions that have resulted in significant decreases in underage drinking.
9. A sustained network of student assistance programs that provide the evidence-based program, Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students), at middle and high schools across the state.
10. A comprehensive, coordinated response to the COVID-19 crisis led Rhode Island to have one of the highest vaccination rates in the country.

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 M/SUD system of care 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 M/SUD system of care.
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, SUD prevention, and SUD treatment goals at the state level.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

2019 State Profile — Rhode Island
National Survey of Substance Abuse Treatment Services (N-SSATS)

The National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual survey of facilities providing substance abuse treatment. It is conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA). The N-SSATS collects data on the location, characteristics, services offered, and number of clients (collected every other year) in treatment at alcohol and drug abuse treatment facilities (public and private) throughout the 50 states, the District of Columbia, U.S. territories, and other jurisdictions.

More information on the methodology used is available in the 2019 N-SSATS report:
https://www.samhsa.gov/data/data-we-collect/n-ssats-national-survey-substance-abuse-treatment-services

In Rhode Island, 59 substance abuse treatment facilities were included in the 2019 N-SSATS report, which reported a total of 8,609 clients in substance abuse treatment on March 29, 2019. The survey response rate in Rhode Island was 98.4 percent.

Facility operation, by number and percent

	Facilities		Clients in treatment on March 29, 2019			
			All clients		Clients under the age of 18 years	
	No.	%	No.	%	No.	%
Private non-profit	37	62.7	5,325	61.9	24	100.0
Private for-profit	19	32.2	3,259	37.9	—	—
Local, county, or community government	—	—	—	—	—	—
State government	—	—	—	—	—	—
Federal government	2	3.4	15	0.2	—	—
Tribal government	1	1.7	10	0.1	—	—
Total	**59**	**100.0**	**8,609**	**100.0**	**24**	**100.0**

Note: Percentages may not sum to 100 percent due to rounding.

Substance abuse problem treated, by number and percent

	Facilities[1]		Clients in treatment on March 29, 2019		
			Clients[2]		Clients[2] per 100,000 pop. aged 18 years or older
	No.	%	No.	%	
Clients with both alcohol and drug abuse	30	71.4	2,003	23.3	233
Clients with drug abuse only	39	92.9	5,656	65.7	661
Clients with alcohol abuse only	27	64.3	950	11.0	110
Total			**8,609**	**100.0**	**1,004**

[1] Numbers of facilities may sum to more than the total, and percentages may sum to more than 100 percent, because facilities may be included in more than one category.
[2] States report *substance abuse problem treated* in terms of percentages of clients, from which the numbers of clients in this table are derived; their sum may not agree with the total due to rounding.

Facility capacity and utilization rate[1]

	Residential	Hospital inpatient
Number of facilities	8	1
Number of clients[2]	211	58
Number of designated beds	224	76
Utilization rate[3]	94.2	76.3
Average number of designated beds per facility	28	76

[1] Excludes facilities not reporting both client counts and number of beds, facilities whose client counts were reported by another facility, facilities that included client counts from other facilities, and facilities that did not respond to this question.
[2] Number of clients on March 29, 2019.
[3] Because substance abuse treatment clients may also occupy non-designated beds, utilization rates may be more than 100 percent.

For a symbol key, see the last page of this profile.

Type of care, by number and percent

	Facilities		Clients in treatment on March 29, 2019					
			All clients				Clients under the age of 18 years	
	No.	%	No.	%	Median no. of clients per OTP facility	Median no. of clients per non-OTP facility	No.	%
Outpatient	**50**	**84.7**	**8,286**	**96.2**	**284**	**111**	**24**	**100.0**
Regular	50	84.7	3,680	42.7	7	44		
Intensive	27	45.8	322	3.7	2	30		
Day treatment or partial hospitalization	5	8.5	—	—	—	—		
Detoxification	16	27.1	8	0.1	3	5		
Methadone/buprenorphine maintenance or naltrexone treatment	30	50.8	4,276	49.7	240	106		
Residential (non-hospital)	**12**	**20.3**	**265**	**3.1**	**50**	**16**	**—**	**—**
Short term (≤ 30 days)	9	15.3	163	1.9	26	16		
Long term (> 30 days)	11	18.6	76	0.9	36	12		
Detoxification	2	3.4	26	0.3	13	—		
Hospital inpatient	**5**	**8.5**	**58**	**0.7**	**58**	**—**	**—**	**—**
Treatment	4	6.8	48	0.6	48	—		
Detoxification	5	8.5	10	0.1	10	—		
Total	**59**		**8,609**	**100.0**	**235**	**45**	**24**	**100.0**

Note: Facilities may provide more than one type of care.

Facility licensing, certification, or accreditation, by number and percent

	No.	%
Any listed agency/organization	56	94.9
State substance abuse agency	49	83.1
State mental health department	40	67.8
State department of health	37	62.7
Hospital licensing authority	4	6.8
The Joint Commission	15	25.4
Commission on Accreditation of Rehabilitation Facilities (CARF)	26	44.1
National Committee for Quality Assurance (NCQA)	—	—
Council on Accreditation (COA)	4	6.8
Healthcare Facilities Accreditation Program (HFAP)	1	1.7
Other national organization or federal, state, or local agency	—	—

Note: Facilities may be licensed, certified, or accredited by more than one agency/organization.

Facility payment options, by number and percent

	No.	%
Cash or self-payment	52	88.1
Private health insurance	54	91.5
Medicare	21	35.6
Medicaid	50	84.7
State-financed health insurance plan other than Medicaid	45	76.3
Federal military insurance	23	39.0
No payment accepted (free treatment for all clients)	—	—
IHS/Tribal/Urban (ITU) funds	2	3.4
Other	—	—
Sliding fee scale	21	35.6
Treatment at no charge or minimal payment for clients who can't pay	17	28.8

Note: Facilities may accept more than one type of payment.

Types of services offered, by number and percent

	Facilities	
	No.	%
Assessment and pre-treatment services		
Screening for substance abuse	57	96.6
Screening for mental health disorders	42	71.2
Comprehensive substance abuse assessment or diagnosis	58	98.3
Comprehensive mental health assessment or diagnosis	38	64.4
Screening for tobacco use	48	81.4
Outreach to persons in the community who may need treatment	38	64.4
Interim services for clients when immediate admission is not possible	26	44.1
Professional interventionist/educational consultant	8	13.6
None of these assessment and pre-treatment services offered	—	—
Testing		
Drug and alcohol oral fluid testing	15	25.4
Breathalyzer or other blood alcohol testing	48	81.4
Drug or alcohol urine screening	57	96.6
Testing for hepatitis B	24	40.7
Testing for hepatitis C	24	40.7
HIV testing	25	42.4
STD testing	16	27.1
TB screening	31	52.5
Testing for metabolic syndrome	6	10.2
None of these testing services offered	1	1.7
Medical services		
Hepatitis A (HAV) vaccination	14	23.7
Hepatitis B (HBV) vaccination	15	25.4
None of these medical services offered	44	74.6
Transitional services		
Discharge planning	58	98.3
Aftercare/continuing care	54	91.5
Naloxone and overdose education	51	86.4
Outcome follow-up after discharge	44	74.6
None of these transitional services offered	—	—
Recovery support services		
Mentoring/peer support	39	66.1
Self-help groups (for example, AA, NA, SMART Recovery)	25	42.4
Assistance in locating housing for clients	42	71.2
Employment counseling or training for clients	27	45.8
Assistance with obtaining social services (for example, Medicaid, WIC, SSI, SSDI)	44	74.6
Recovery coach	27	45.8
None of these recovery support services offered	7	11.9
Education and counseling services		
HIV or AIDS education, counseling, or support	44	74.6
Hepatitis education, counseling, or support	44	74.6
Health education other than HIV/AIDS or hepatitis	43	72.9
Substance abuse education	58	98.3
Smoking/ tobacco cessation counseling	48	81.4
Individual counseling	58	98.3

Continued

Types of services offered, by number and percent (continued)

	Facilities	
	No.	%
Group counseling	52	88.1
Family counseling	44	74.6
Marital/couples counseling	33	55.9
Vocational training or educational support	11	18.6
None of these education and counseling services offered	—	—
Pharmacotherapies		
Disulfiram (Antabuse®)	25	42.4
Naltrexone (oral)	24	40.7
Naltrexone (extended-release, injectable, for example, Vivitrol®)	29	49.2
Acamprosate (Campral®)	19	32.2
Nicotine replacement	31	52.5
Non-nicotine smoking/tobacco cessation medications (for example, bupropion, varenicline)	19	32.2
Medications for psychiatric disorders	37	62.7
Methadone[1]	21	35.6
Buprenorphine with naloxone (for example, Suboxone®, Bunavail®, Zubsolv®, Cassipa®)	34	57.6
Buprenorphine without naloxone	23	39.0
Buprenorphine sub-dermal implant (Probuphine®)	3	5.1
Buprenorphine (extended-release, injectable, for example, Sublocade®)	14	23.7
Medications for HIV treatment (for example, antiretroviral medications such as tenofovir, efavirenz, emtricitabine, atazanavir, and lamivudine)	11	18.6
Medications for hepatitis C (HCV) treatment (for example, sofosbuvir, ledipasvir, interferon, peginterferon, ribavirin)	11	18.6
Lofexidine	3	5.1
Clonidine	15	25.4
None of these pharmacotherapy services offered	12	20.3
Ancillary services		
Case management services	51	86.4
Social skills development	46	78.0
Child care for clients' children	3	5.1
Domestic violence—family or partner violence services (physical, sexual, and emotional abuse)	23	39.0
Early intervention for HIV	24	40.7
Transportation assistance to treatment	37	62.7
Mental health services	47	79.7
Acupuncture	8	13.6
Residential beds for clients' children	1	1.7
None of these ancillary services offered	1	1.7
Other services		
Treatment for gambling disorder	25	42.4
Treatment for Internet use disorder	8	13.6
Treatment for other addiction disorder (non-substance abuse)	16	27.1
None of these 'other' services offered	29	49.2

[1] Methadone is available only at OTP facilities that are certified by SAMHSA's Center for Substance Abuse Treatment.

For a symbol key, see the last page of this profile.

Clinical/therapeutic approaches used frequently, by number and percent

	Facilities	
	No.	%
Substance abuse counseling	56	94.9
12-step facilitation	37	62.7
Brief intervention	54	91.5
Cognitive behavioral therapy	55	93.2
Dialectical behavior therapy	37	62.7
Contingency management/motivational incentives	33	55.9
Motivational interviewing	51	86.4
Trauma-related counseling	47	79.7
Anger management	45	76.3
Matrix model	15	25.4
Community reinforcement plus vouchers	8	13.6
Rational emotive behavioral therapy (REBT)	14	23.7
Relapse prevention	57	96.6
Telemedicine/telehealth	11	18.6
Other treatment approaches	3	5.1
We do not use any of these clinical/therapeutic approaches	—	—

Specifically tailored programs or groups, by number and percent

	Facilities	
	No.	%
Any program or group	50	84.7
Adolescents	4	6.8
Young adults	12	20.3
Adult women	32	54.2
Pregnant or postpartum women	23	39.0
Adult men	27	45.8
Seniors or older adults	11	18.6
LGBT clients	8	13.6
Veterans	8	13.6
Active duty military	4	6.8
Members of military families	3	5.1
Criminal justice clients (other than DUI/DWI)	17	28.8
Clients with co-occurring mental and substance use disorders	27	45.8
Clients with co-occurring pain and substance use	4	6.8
Clients with HIV or AIDS	9	15.3
Clients who have experienced sexual abuse	10	16.9
Clients who have experienced intimate partner violence, domestic violence	9	15.3
Clients who have experienced trauma	17	28.8
DUI/DWI clients	13	22.0
Other	6	10.2
No specifically tailored programs or groups are offered	9	15.3

DUI/DWI = driving under the influence/driving while intoxicated or impaired; LGBT = lesbian, gay, bisexual, or transgender.

Facility funding, by number and percent

	Facilities	
	No.	%
Receives federal, state, county, or local government funds or grants for substance use treatment programs	33	55.9

Services in sign language for the deaf and hard-of-hearing and in languages other than English, by number and percent

	Facilities	
	No.	%
Sign language	20	33.9
Any language other than English	40	67.8
Non-English language provided by		
Staff counselor only	10	25.0
On-call interpreter only	20	50.0
Both staff counselor and on-call interpreter	10	25.0
Languages provided by staff counselor[1]		
Spanish	19	95.0
American Indian/Alaska Native languages	—	—
Other	6	30.0

[1] Numbers and percentages are based on facilities that provide language services through a staff counselor, either exclusively or in conjunction with on-call interpreters.

Symbol key (where applicable)

— Quantity is zero; * Less than 0.05 percent;
† Less than 1 per 100,000; ‡ No facilities in this category.

Clients receiving medication-assisted opioid therapy (MAOT) at facilities with opioid treatment programs (OTPs) and non-OTP facilities, by number and percent

	No.	%
Facilities with OTPs[1]	**22**	**1.3**
Clients in facilities with OTPs[2]		
Any MAT[3]	4,519	1.0
Methadone	4,222	1.0
Buprenorphine	281	0.8
Naltrexone	16	0.5
Clients in facilities without OTPs[4]		
Any MAT[5]	575	0.4
Buprenorphine	533	0.4
Naltrexone	42	0.2

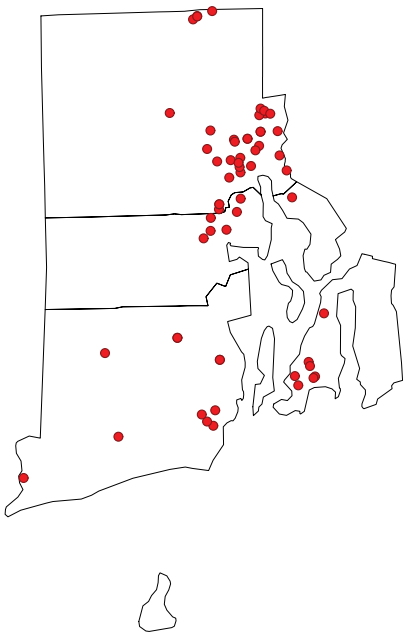
[1] Percentage of all facilities with OTPs in the U.S. [2] Percentage of all clients receiving methadone, buprenorphine, or naltrexone at facilities with OTPs in the U.S; see 2019 N-SSATS report for details. [3] Consists of clients receiving methadone, buprenorphine, or naltrexone. [4] Percentage of all clients receiving buprenorphine or naltrexone at non-OTP facilities in the U.S; see 2019 N-SSATS report for details. [5] Consists of clients receiving buprenorphine or naltrexone.

Clients per 100,000 population receiving MAOT in OTP facilities on March 29, 2019

	No.
Any type of medication-assisted therapy[1]	427
Methadone	399
Buprenorphine	27
Naltrexone	2

[1] Includes clients receiving methadone, buprenorphine, or naltrexone.

Location of treatment facilities



Data in this profile are from facilities that reported to the N-SSATS and are based on the survey's reference date, March 29, 2019.

The latest N-SSATS report, and other substance abuse reports, are available at: https://www.samhsa.gov/data/data-we-collect/n-ssats-national-survey-substance-abuse-treatment-services

Access the latest N-SSATS public use files at: https://datafiles.samhsa.gov

For information on individual facilities, access SAMHSA's Behavioral Health Treatment Services Locator at: https://findtreatment.samhsa.gov/

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Behavioral Health Statistics and Quality
www.samhsa.gov/data

https://www.samhsa.gov/data/quick-statistics

Rhode Island 2020 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System

Utilization Rates/Number of Consumers Served	U.S.	State	U.S. Rate	States
Penetration Rate per 1,000 population	8,013,396	29.79	24.58	58
Community Utilization per 1,000 population	7,801,366	29.68	23.93	58
State Hospital Utilization per 1,000 population	125,305	0.19	0.38	53
Other Psychiatric Inpatient Utilization per 1,000 population	408,959	-	1.47	40

Adult Employment Status	U.S.	State	U.S. Rate	States
Employed (Percent in Labor Force)*	776,983	40.1%	47.1%	57
Employed (percent with Employment Data)**	776,983	21.0%	23.6%	57

Adult Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	74.5%	79.6%	49

Child/Family Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	-	74.6%	45

Readmission Rates:(Civil "non-Forensic" clients)	U.S.	State	U.S. Rate	States
State Hospital Readmissions: 30 Days	7,008	0.0%	9.2%	48
State Hospital Readmissions: 180 Days	15,085	0.0%	19.9%	49
State Hospital Readmissions: 30 Days: Adults	6,499	0.0%	9.4%	48
State Hospital Readmissions: 180 Days: Adults	13,916	0.0%	20.2%	49
State Hospital Readmissions: 30 Days: Children	509	0.0%	7.3%	16
State Hospital Readmissions: 180 Days: Children	1,169	0.0%	16.7%	19

Living Situation	U.S.	State	U.S. Rate	States
Private Residence	4,199,185	85.6%	84.7%	57
Homeless/Shelter	216,731	7.2%	4.4%	52
Jail/Correctional Facility	72,275	0.4%	1.5%	51

Adult EBP Services	U.S.	State	U.S. Rate	States
Supported Housing	70,648	0.7%	2.3%	30
Supported Employment	66,662	3.6%	1.9%	41
Assertive Community Treatment	66,159	8.9%	1.8%	42
Family Psychoeducation	37,853	-	3.1%	16
Dual Diagnosis Treatment	199,597	16.2%	9.5%	24
Illness Self Management	308,378	-	19.1%	22
Medications Management	545,051	15.9%	31.3%	21

Child/Adolescent EBP Services	U.S.	State	U.S. Rate	States
Therapeutic Foster Care	13,178	-	1.7%	21
Multisystemic Therapy	31,303	-	4.1%	20
Functional Family Therapy	31,817	-	5.8%	15

Change in Social Connectedness	State	U.S. Rate	States
Adult Improved Social Connectedness	78.9%	79.2%	46
Child/Family Improved Social Connectedness	-	88.4%	42

*Denominator is the sum of consumers employed and unemployed.
**Denominator is the sum of consumers employed, unemployed, and not in labor force.

SAMHSA Uniform Reporting System - 2020 State Mental Health Measures

Rhode Island

Utilization	State Number	State Rate	U.S.	U.S. Rate	States
Penetration Rate per 1,000 population	31,547	29.79	8,013,396	24.58	58
Community Utilization per 1,000 population	31,432	29.68	7,801,366	23.93	58
State Hospital Utilization per 1,000 population	203	0.19	125,305	0.38	53
Medicaid Funding Status	21,978	71%	5,588,185	72%	57
Employment Status (percent employed)	3,952	21%	776,983	24%	57
State Hospital Adult Admissions	54	0.27	94,482	0.80	51
Community Adult Admissions	6,359	0.25	12,057,441	2.43	51
Percent Adults with SMI and Children with SED	28,406	90%	5,737,430	72%	58

Utilization	State Rate	U.S. Rate	States
State Hospital LOS Discharged Adult patients (Median)	190 Days	87 Days	49
State Hospital LOS for Adult Resident patients in facility <1 year (Median)	130 Days	107 Days	49
Percent of Client who meet Federal SMI definition	78%	72%	55
Adults with Co-occurring MH/SA Disorders	53%	28%	56
Children with Co-occurring MH/SA Disorders	11%	8%	54

Adult Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	95.0%	88.9%	49
Quality/Appropriateness of Services	94.7%	90.8%	48
Outcome from Services	74.5%	79.6%	49
Participation in Treatment Planning	94.5%	86.9%	47
General Satisfaction with Care	92.6%	90.1%	48

Child/Family Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	-	89.2%	46
General Satisfaction with Care	-	89.2%	47
Outcome from Services	-	74.6%	45
Participation in Treatment Planning	-	89.4%	46
Cultural Sensitivity of Providers	-	94.6%	43

Consumer Living Situations	State Number	State Rate	U.S.	U.S. Rate	States
Private Residence	21,104	85.6%	4,199,185	84.7%	57
Jail/Correctional Facility	103	0.4%	72,275	1.5%	51
Homeless or Shelter	1,767	7.2%	216,731	4.4%	52

Hospital Readmissions	State Number	State Rate	U.S.	U.S. Rate	States
State Hospital Readmissions: 30 Days	0	0.0%	7,008	9.2%	48
State Hospital Readmissions: 180 Days	0	0.0%	15,085	19.9%	49
Readmission to any psychiatric hospital: 30 Days	-	-	34,681	17.7%	20

State Mental Health Finance (2020)	State Number	State Rate	U.S.	U.S. Rate	States
SMHA Expenditures for Community Mental Health*	$62,632,795	84.4%	$32,043,740,071	69.8%	59
State Expenditures from State Sources	$1,680,036	2.3%	$17,673,556,338	38.5%	56
Total SMHA Expenditures	$74,211,639	-	$45,901,588,603	-	59

Adult Evidence-Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Assertive Community Treatment	1,801	8.9%	66,159	1.8%	42
Supported Housing	152	0.7%	70,648	2.3%	30
Supported Employment	733	3.6%	66,662	1.9%	41
Family Psychoeducation	-	-	37,853	3.1%	16
Integrated Dual Diagnosis Treatment	3,294	16.2%	199,597	9.5%	24
Illness Self-Management and Recovery	-	-	308,378	19.1%	22
Medications Management	3,216	15.9%	545,051	31.3%	21

Child Evidence Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Therapeutic Foster Care	-	-	13,178	1.7%	21
Multisystemic Therapy	-	-	31,303	4.1%	20
Functional Family Therapy	-	-	31,817	5.8%	15

Outcome	State Number	State Rate	U.S.	U.S. Rate	States
Adult Criminal Justice Contacts	1,174	4.8%	26,620	2.7%	32
Juvenile Justice Contacts	-	-	4,542	1.2%	35
School Attendance (Improved)	-	-	10,488	28.9%	22

* Includes primary prevention, evidence-based practices for early serious mental illness, and Other 24-Hour Care

Mental Health Community Services Block Grant: 2020 State Summary Report

Rhode Island

State URS Contact Person
Mackenzie Daly
14 Harrington Road Cranston, RI 02920
401-462-6008
mackenzie.daly@bhddh.ri.gov

State Revenue Expenditure Data	Amount
FY 2020 Mental Health Block Grant Expenditures	$2,020,120
FY 2020 SMHA Community MH Expenditures	$62,632,795
FY 2020 Per Capita Community MH Expenditures	$59.37
FY 2020 Community Percent of Total SMHA Spending	83.38%
FY 2020 Total SMHA Mental Health Expenditure	$74,211,639
FY 2020 Per Capita Total SMHA Mental Health Expenditures	$70.35

Statewide Mental Health Agency Data*

Measure	Number of Clients	Utilization Rate Per 1,000 Population
Total Clients Served by SMHA System	31,547	29.8
Clients Served in Community Settings	31,432	29.7
Clients Served in State Hospitals	203	0.2

Gender	Percent
Female	50.1%
Male	49.9%
Not Available	0.0%

Race/Ethnicity	Percent
American Indian or Alaska Native	0.7%
Asian	1.0%
Black or African American	11.9%
Native Hawaiian or Other Pacific Islander	0.2%
White	68.1%
More Than One Race	3.5%
Not Available	14.5%

Employment With Known Status (Adults)	Percent
Employed	21.0%
Unemployed	31.3%
Not In Labor Force	47.7%

Medicaid Funding Status of Consumers	Percent
Medicaid Only	15.2%
Non-Medicaid	29.0%
Both Medicaid and Other Funds	55.8%

Consumer Perception of Care: (Adults)	Percent
Access to Services	95.0%
Quality/Appropriateness of Services	94.7%
Outcome from Services	74.5%
Participation in Treatment Planning	94.5%
Overall Satisfaction with Care	92.6%

Implementation of Evidence-Based Practices	Percent
Assertive Community Treatment	8.9%
Supported Housing	0.7%
Supported Employment	3.6%
Family Psychoeducation	-
Integrated Dual Diagnosis Treatment	16.2%
Illness Self-Management and Recovery	-
Medications Management	15.9%
Therapeutic Foster Care	-
Multisystemic Therapy	-
Functional Family Therapy	-

Age	Percent
0 to 12	10.3%
13 to 17	10.1%
18 to 20	5.5%
21 to 24	5.8%
25 to 44	30.1%
45 to 64	31.3%
65 to 74	5.6%
75 and over	1.4%
Not Available	-

Living Situation (with Known Status)	Percent
Private Residence	85.6%
Foster Home	0.4%
Residential Care	5.8%
Crisis Residence	-
Residential Treatment Center	-
Institutional Setting	0.6%
Jail (Correctional Facility)	0.4%
Homeless (Shelter)	7.2%
Other	-

Consumer Perception of Care: (Children/Adolescents)	Percent
Access to Services	-
Overall Satisfaction with Care	-
Outcome from Services	-
Participation in Treatment Planning	-
Cultural Sensitivity of Providers	-

Outcome Measures Developmental	Percent
Adults Arrested this Year	4.8%
Youth Arrested this Year	-
Improved School Attendance	-

Hospital Readmissions (Civil Status Patients)	Percent
State Hospital Readmissions: 30 Days	-
State Hospital Readmissions: 180 Days	-
Readmission to any psychiatric hospital: 30 Days	-

* Based on 2020 URS data provided by US States and Territories per annual reporting guidelines.

The Community Mental Health Block Grant is administered by the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services

Access Domain: Demographic Characteristics of Persons Served by the State Mental Health Authority, FY 2020

Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Demographics	Total Served				Penetration Rates (per 1,000 population)			States Reporting
	State		US					
	n	%	n	%	State	Northeast	US	
Total	**31,547**	**100.0%**	**8,013,396**	**100.0%**	**29.8**	**36.6**	**24.6**	**58**
0-12	3,243	10.3%	1,249,365	15.6%	22.6	33.3	24.4	58
13-17	3,176	10.1%	963,341	12.0%	52.0	66.7	47.1	58
18-20	1,744	5.5%	378,464	4.7%	34.2	39.6	30.0	58
21-24	1,815	5.8%	455,776	5.7%	31.0	36.5	26.7	58
25-44	9,485	30.1%	2,562,474	32.0%	34.7	41.5	29.8	58
45-64	9,870	31.3%	1,924,296	24.0%	34.7	37.4	23.6	58
65-74	1,768	5.6%	318,939	4.0%	16.7	22.4	10.3	57
75 and over	446	1.4%	135,263	1.7%	5.5	15.9	6.1	58
Age Not Available	-	-	25,478	0.3%	-	-	-	25
Female	15,816	50.1%	4,165,457	52.0%	29.1	37.2	25.2	58
Male	15,729	49.9%	3,806,212	47.5%	30.5	35.8	23.7	58
Gender Not Available	2	0.0%	41,727	0.5%	-	-	-	37
American Indian/Alaskan Native	234	0.7%	144,169	1.8%	20.4	27.3	34.7	52
Asian	321	1.0%	113,401	1.4%	8.1	9.5	5.9	56
Black/African American	3,742	11.9%	1,406,075	17.5%	41.5	56.1	33.3	54
Native Hawaiian/Pacific Islander	67	0.2%	20,489	0.3%	31.5	44.9	26.2	51
White	21,499	68.1%	4,752,713	59.3%	24.3	27.6	19.2	56
Multi-Racial	1,116	3.5%	217,180	2.7%	36.4	29.4	26.3	48
Race Not Available	4,568	14.5%	1,359,369	17.0%	-	-	-	51
Hispanic or Latino Ethnicity	7,018	22.2%	1,229,256	16.9%	40.7	41.5	21.5	51
Not Hispanic or Latino Ethnicity	21,506	68.2%	5,515,915	75.9%	24.3	33.8	22.0	55
Ethnicity Not Available	3,023	9.6%	518,733	7.1%	-	-	-	43

Note:

Are Client Counts Unduplicated? Unduplicated **Number of States with Unduplicated Counts** 43

This table uses data from URS Table 2a, Table 2b and from the US Census Bureau. All denominators use US Census data from 2019

US totals are calculated uniquely for each data element based on only those states who reported clients served.

Regional groupings are based on SAMHSA's Block Grant Regions.

State Notes:

Table 2a

Age	Age calculated at midpoint of reporting period
Gender	None
Race	None
Overall	Populated by NRI using Rhode Island's 2020 MH CLD-BCI dataset.

Table 2b

Age	Age calculated at midpoint of reporting period
Gender	None
Race	None
Overall	Populated by NRI using Rhode Island's 2020 MH CLD-BCI dataset.

Access Domain: Persons Served in Community Mental Health Programs by Age and Gender, FY 2020

Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Demographic	Served in Community				Penetration Rates (rate per 1,000 population)		States Reporting
	State		US				
	n	%	n	%	State	US	
Age 0-17	6,418	20.4%	2,189,167	28.1%	31.4	30.5	58
Age 18-20	1,744	5.5%	366,512	4.7%	34.2	29.0	58
Age 21-64	21,077	67.1%	4,786,066	61.3%	34.2	25.9	58
Age 65+	2,193	7.0%	436,181	5.6%	11.7	7.7	58
Age Not Available	-	-	23,440	0.3%	-	-	26
Age Total	31,432	100.0%	7,801,366	100.0%	29.7	23.9	58
Female	15,784	50.2%	4,086,098	52.4%	29.0	24.7	58
Male	15,646	49.8%	3,675,816	47.1%	30.3	22.9	58
Gender Not Available	2	0.0%	39,452	0.5%	-	-	36
Total	31,432	100.0%	7,801,366	100.0%	29.7	23.9	58

Note:

US totals are based on states reporting.

This table uses data from URS Table 3.

US penetration rates are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.

State Notes:

Age	Age calculated at midpoint of reporting period
Gender	None
Overall	Populated by NRI using Rhode Island's 2020 MH CLD-BCI dataset.

Access Domain: Persons Served in State Psychiatric Hospitals by Age and Gender, FY 2020

Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Demographic	Served in State Psychiatric Hospitals				Penetration Rates (rate per 1,000 population)		States Reporting
	State		US				
	n	%	n	%	State	US	
Age 0-17	1	0.5%	7,472	6.0%	0.0	0.2	33
Age 18-20	2	1.0%	5,035	4.0%	0.0	0.4	52
Age 21-64	174	85.7%	104,890	83.7%	0.3	0.6	53
Age 65+	26	12.8%	7,905	6.3%	0.1	0.1	53
Age Not Available	-	-	3	0.0%	-	-	3
Age Total	203	100.0%	125,305	100.0%	0.2	0.4	53
Female	57	28.1%	41,479	33.1%	0.1	0.3	53
Male	146	71.9%	83,626	66.7%	0.3	0.5	53
Gender Not Available	-	-	200	0.2%	-	-	9
Total	203	100.0%	125,305	100.0%	0.2	0.4	53

Notes:

US totals are based on states reporting.

This table uses data from URS Table 3.

US penetration rates are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.

State Notes:

Age	Age calculated at midpoint of reporting period
Gender	None
Overall	Populated by NRI using Rhode Island's 2020 MH CLD-BCI dataset.

Access Domain: Demographic Characteristics of Adults with SMI and Children with SED Served by the State Mental Health Authority, FY 2020

Rhode Island

Reporting Period: 7/1/2019 To: 6/30/2020

Demographics	Total Served				Penetration Rates (per 1,000 population)			States Reporting
	State		US					
	n	%	n	%	State	Northeast	US	
Total	28,406	100.0%	5,737,430	100.0%	26.8	24.0	17.3	58
0-12	2,956	10.4%	905,892	15.8%	20.6	18.3	17.3	58
13-17	2,833	10.0%	730,917	12.7%	46.4	45.9	35.1	57
18-20	1,513	5.3%	263,228	4.6%	29.7	26.8	20.5	57
21-24	1,525	5.4%	315,930	5.5%	26.0	25.0	18.2	58
25-44	8,338	29.4%	1,787,313	31.2%	30.5	27.6	19.4	58
45-64	9,178	32.3%	1,426,172	24.9%	32.2	26.0	17.1	58
65-74	1,648	5.8%	223,834	3.9%	15.5	14.5	7.1	56
75 and over	415	1.5%	80,189	1.4%	5.1	8.6	3.9	56
Age Not Available	-	-	3,955	0.1%	-	-	-	17
Female	14,527	51.1%	3,037,425	52.9%	26.7	25.0	18.0	58
Male	13,878	48.9%	2,687,150	46.8%	26.9	23.0	16.4	58
Gender Not Available	1	0.0%	12,855	0.2%	-	-	-	34
American Indian/Alaskan Native	218	0.8%	92,691	1.6%	19.0	16.3	22.1	52
Asian	290	1.0%	86,072	1.5%	7.3	6.6	4.4	55
Black/African American	3,357	11.8%	1,044,715	18.2%	37.3	37.7	23.7	53
Native Hawaiian/Pacific Islander	59	0.2%	15,358	0.3%	27.8	32.4	19.0	51
White	19,521	68.7%	3,361,894	58.6%	22.0	18.0	13.4	54
Multi-Racial	1,012	3.6%	177,013	3.1%	33.0	24.6	19.4	48
Race Not Available	3,949	13.9%	959,687	16.7%	-	-	-	49
Hispanic or Latino Ethnicity	6,358	22.4%	1,009,157	19.0%	36.8	29.0	16.7	51
Not Hispanic or Latino Ethnicity	19,435	68.4%	3,930,960	74.1%	21.9	22.0	14.7	55
Ethnicity Not Available	2,613	9.2%	365,714	6.9%	-	-	-	43

Note:
This table uses data from URS Table 14a, Table 14b and from the US Census Bureau. All denominators use US Census data from 2019

US totals are calculated uniquely for each data element based on only those states who reported clients served.

Regional groupings are based on SAMHSA's Block Grant Regions.

State Notes:

Table 14a

Age	Age calculated at midpoint of reporting period
Gender	None
Race	None
Overall	Populated by NRI using Rhode Island's 2020 MH CLD-BCI dataset.

Table 14b

Age	Age calculated at midpoint of reporting period
Gender	None
Race	None
Overall	Populated by NRI using Rhode Island's 2020 MH CLD-BCI dataset.

Access Domain: Adults with SMI and Children with SED Served in Community Mental Health Programs by Age and Gender, FY 2020

Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Demographic	Served in Community				Penetration Rates (rate per 1,000 population)		States Reporting
	State		US				
	n	%	n	%	State	US	
Age 0-17	5,788	20.4%	1,585,185	28.9%	28.3	22.2	57
Age 18-20	1,513	5.3%	248,765	4.5%	29.7	19.8	56
Age 21-64	19,012	67.0%	3,360,167	61.3%	30.8	18.2	57
Age 65+	2,058	7.3%	283,618	5.2%	11.0	5.0	56
Age Not Available	-	-	3,238	0.1%	-	-	16
Age Total	28,371	100.0%	5,480,973	100.0%	26.8	16.9	57
Female	14,519	51.2%	2,925,437	53.4%	26.7	17.7	57
Male	13,851	48.8%	2,544,436	46.4%	26.9	15.9	57
Gender Not Available	1	0.0%	11,100	0.2%	-	-	34
Total	28,371	100.0%	5,480,973	100.0%	26.8	16.9	57

Note:

US totals are based on states reporting.

This table uses data from URS Table 15a.

US penetration rates are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.

State Notes:

Age	Age calculated at midpoint of reporting period
Gender	None
Overall	Populated by NRI using Rhode Island's 2020 MH CLD-BCI dataset.

Access Domain: Adults with SMI and Children with SED Served in State Psychiatric Hospitals by Age and Gender, FY 2020

Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Demographic	Served in State Psychiatric Hospitals				Penetration Rates (rate per 1,000 population)		States Reporting
	State		US				
	n	%	n	%	State	US	
Age 0-17	1	0.8%	5,988	6.2%	0.0	0.1	28
Age 18-20	2	1.6%	3,722	3.8%	0.0	0.3	48
Age 21-64	109	89.3%	81,222	84.0%	0.2	0.4	51
Age 65+	10	8.2%	5,801	6.0%	0.1	0.1	50
Age Not Available	-	-	2	0.0%	-	-	2
Age Total	122	100.0%	96,735	100.0%	0.1	0.3	51
Female	33	27.0%	30,627	31.7%	0.1	0.2	51
Male	89	73.0%	66,072	68.3%	0.2	0.4	51
Gender Not Available	-	-	36	0.0%	-	-	5
Total	122	100.0%	96,735	100.0%	0.1	0.3	51

Notes:

US totals are based on states reporting.

This table uses data from URS Table 15a.

US penetration rates are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.

State Notes:

Age	Age calculated at midpoint of reporting period
Gender	None
Overall	Populated by NRI using Rhode Island's 2020 MH CLD-BCI dataset.

Appropriateness Domain: Percent of Adults and Children Served Who Meet the Federal Definition for SMI/SED and Percent of Adults and Children Served Who Have Co-Occurring MH/AOD Disorders, FY 2020

Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Adults and Children who meet the Federal Definition of SMI/SED	State	US Average	US Median	States Reporting
Percent of Adults served through the SMHA who meet the Federal definition for SMI	78.2%	71.6%	77.0%	55
Percent of Children served through the SMHA who meet the Federal definition for SED	39.6%	71.1%	75.0%	55

Co-occurring MH and Substance Abuse Consumers	State	US Average	US Median	States Reporting
Percent of Adults served through the SMHA who had a co-occurring MH and AOD disorder	52.7%	28.0%	25.0%	56
Percent of Children served through the SMHA who had a co-occurring MH and AOD disorder	11.1%	8.1%	3.0%	55
Percent of Adults served through the SMHA who met the Federal definitions of SMI who also have a substance abuse diagnosis	54.1%	27.4%	24.5%	54
Percent of Children served through the SMHA who met the Federal definitions of SED who also have a substance abuse diagnosis	14.2%	9.6%	3.0%	54

Note

This table uses data from URS Table 12.

How are the number of clients with co-occurring disorders counted and calculated?

Clients in a mental health program who have 'Yes' for co-occuring diagnosis indicator and/or have a primary substance of abuse listed.

State Notes

None

ACCESS DOMAIN: Persons Served by SMHA System through Medicaid and Other Funding Sources by Race, Gender, and Ethnicity, FY 2020

STATE: Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Demographic	State							US Averages							States Reporting
	Number Served				% Served			Number Served				% Served			
	Medicaid Only	Non-Medicaid Only	Both Medicaid & Other	Total Served with Known Funding Status	Medicaid Only	Non-Medicaid Only	Both Medicaid & Other	Medicaid Only	Non-Medicaid Only	Both Medicaid & Other	Total Served with Known Funding Status	Medicaid Only	Non-Medicaid Only	Both Medicaid & Other	
Female	2,512	4,593	8,481	15,586	16%	29%	54%	2,463,327	1,077,711	505,036	4,046,074	61%	27%	12%	56
Male	2,182	4,404	8,803	15,389	14%	29%	57%	2,124,444	1,064,218	482,257	3,670,919	58%	29%	13%	56
Gender Not Available	-	1	-	1	-	100%	-	11,635	22,580	1,486	35,701	33%	63%	4%	35
Total	4,694	8,998	17,284	30,976	15%	29%	56%	4,599,406	2,164,509	988,779	7,752,694	59%	28%	13%	56
American Indian or Alaska Native	33	53	145	231	14%	23%	63%	99,608	23,612	18,235	141,455	70%	17%	13%	51
Asian	41	84	189	314	13%	27%	60%	66,719	27,148	13,698	107,565	62%	25%	13%	54
Black or African American	564	843	2,260	3,667	15%	23%	62%	789,858	380,512	189,234	1,359,604	58%	28%	14%	52
Native Hawaiian or Other Pacific Islander	6	19	39	64	9%	30%	61%	10,669	4,515	4,037	19,221	56%	23%	21%	49
White	3,169	6,327	11,630	21,126	15%	30%	55%	2,682,757	1,368,468	556,354	4,607,579	58%	30%	12%	54
More Than One Race	44	295	770	1,109	4%	27%	69%	114,879	63,333	34,947	213,159	54%	30%	16%	46
Race Not Available	837	1,377	2,251	4,465	19%	31%	50%	834,916	296,921	172,274	1,304,111	64%	23%	13%	49
Total	4,694	8,998	17,284	30,976	15%	29%	56%	4,599,406	2,164,509	988,779	7,752,694	59%	28%	13%	56
Hispanic or Latino	1,084	1,531	4,291	6,906	16%	22%	62%	693,741	294,182	204,204	1,192,127	58%	25%	17%	50
Not Hispanic or Latino	3,322	6,184	11,562	21,068	16%	29%	55%	3,009,937	1,635,495	696,061	5,341,493	56%	31%	13%	54
Ethnicity Not Available	288	1,283	1,431	3,002	10%	43%	48%	252,687	146,693	70,965	470,345	54%	31%	15%	40
Total	4,694	8,998	17,284	30,976	15%	29%	56%	3,956,365	2,076,370	971,230	7,003,965	56%	30%	14%	54

Note:

This table uses data from URS tables 5a and 5b.

Type of Medicaid Data Reported

Data based on Medicaid Eligibility, not Medicaid Paid Services.

State Notes

5a	Race	None
5a	Gender	None
5a	Overall	Populated by NRI using Rhode Island's 2020 MH CLD-BCI dataset.
5b	Overall	Populated by NRI using Rhode Island's 2020 MH CLD-BCI dataset.

APPROPRIATENESS DOMAIN: NUMBER OF ADMISSIONS DURING THE YEAR TO STATE HOSPITAL INPATIENT AND COMMUNITY-BASED PROGRAMS, FY 2020

STATE: Rhode Island

Reporting Period: 7/1/2019 To: 6/30/2020

Setting	Demographic	State			US			Admission Rate		States Reporting
		Admissions During Year	Total Served At Start of Year	Total Served During Year	Admissions During Year	Total Served At Start of Year	Total Served During Year	State	US	
State Psychiatric Hospitals	Total	54	135	203	101,901	40,180	124,957	0.27	0.82	51
	Children	-	-	1	7,410	1,407	7,315	-	1.01	29
	Adults	54	135	202	94,482	38,756	117,636	0.27	0.80	51
	Age NA	-	-	-	9	17	-	-	-	1
Other Inpatient	Total	-	-	-	411,756	50,612	381,371	-	1.08	36
	Children	-	-	-	57,707	4,588	50,049	-	1.15	31
	Adults	-	-	-	353,599	45,801	329,867	-	1.07	36
	Age NA	-	-	-	450	223	129	-	3.49	7
Residential Treatment Centers	Total	-	-	-	39,150	16,069	50,133	-	0.78	35
	Children	-	-	-	11,615	5,185	12,691	-	0.92	34
	Adults	-	-	-	27,533	10,883	37,287	-	0.74	28
	Age NA	-	-	-	2	1	2	-	1.00	2
Community Programs	Total	8,385	21,157	31,432	21,703,308	3,908,937	6,880,155	0.27	3.15	51
	Children	2,026	4,173	6,418	9,619,103	1,047,521	1,918,288	0.32	5.01	51
	Adults	6,359	16,984	25,014	12,057,441	2,838,566	4,954,989	0.25	2.43	51
	Age NA	-	-	-	26,764	22,850	5,727	-	4.67	16

Note:

Admission Rate= number of admissions divided by total served during the year

US Admissions During Year uses data from states reporting data only. States are only included in "US Total Served" if they also reported data on admissions.

US Total Served During Year is calculated using data in URS Table 3.

This table uses data from URS Table 3 and 6.

Table 3 State Notes:

Age	Age calculated at midpoint of reporting period
Overall	Populated by NRI using Rhode Island's 2020 MH CLD-BCI dataset.
Gender	None

Table 6 State Notes:

Hospital	None
Other Inpatient	None
Residential	None
Community	None
Overall	None

APPROPRIATENESS DOMAIN: Length of Stays in State Psychiatric Hospitals, Other Psychiatric Inpatient and Residential Treatment Centers for Children Settings, FY 2020

STATE: Rhode Island

Reporting Period: 7/1/2019 To: 6/30/2020

Setting	Demographic	State						US						
		Length of Stay (Days)						Length of Stay (Days)						
		Discharged Clients		Resident Clients in Facility 1 year or less		Resident Clients in Facility more than 1 year		Discharged Clients		Resident Clients in Facility 1 year or less		Resident Clients in Facility more than 1 year		States
		Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Reporting
State Hospitals	All	-	-	-	-	-	-	160	71	99	81	1,707	862	16
	Children	-	-	-	-	-	-	88	75	86	77	611	561	24
	Adults	318	190	145	130	3,244	2,589	228	87	126	107	1,757	1,013	50
	Age NA	-	-	-	-	-	-	37	5	-	-	2,191	1,807	-
Other Inpatient	All	-	-	-	-	-	-	54	39	66	50	696	580	9
	Children	-	-	-	-	-	-	39	32	47	38	423	391	23
	Adults	-	-	-	-	-	-	71	40	62	46	790	576	32
	Age NA	-	-	-	-	-	-	15	13	269	269	-	-	1
Residential Treatment Centers	All	-	-	-	-	-	-	217	124	142	144	721	669	4
	Children	-	-	-	-	-	-	165	128	135	128	660	615	26
	Adults	-	-	-	-	-	-	296	259	149	137	968	824	22
	Age NA	-	-	-	-	-	-	109	109	94	94	441	387	1

Note:

Resident clients are clients who were receiving services in inpatient settings at the end of the reporting period.

This table uses data from URS Table 6.

Table 6 State Notes:

Hospital	None
Other Inpatient	None
Residential	None
Community	None
Overall	None

APPROPRIATENESS DOMAIN: Living Situation of Consumers Served by State Mental Health Agency Systems, FY 2020

STATE: Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Age Group	Setting	State			US			States Reporting
		Living Situation	Percent in Living Situation	Percent with Known Living Situation	Living Situation	Percent in Living Situation	Percent with Known Living Situation	
All Persons Served	Private Residence	21,104	66.9%	85.6%	4,199,185	57.3%	84.7%	57
	Foster Home	100	0.3%	0.4%	61,475	0.8%	1.2%	48
	Residential Care	1,422	4.5%	5.8%	173,289	2.4%	3.5%	52
	Crisis Residence	-	-	-	8,543	0.1%	0.2%	29
	Residential Treatment Center	-	-	-	9,138	0.1%	0.2%	35
	Institutional Setting	156	0.5%	0.6%	90,396	1.2%	1.8%	51
	Jail (Correctional Facility)	103	0.3%	0.4%	72,275	1.0%	1.5%	51
	Homeless (Shelter)	1,767	5.6%	7.2%	216,731	3.0%	4.4%	52
	Other	-	-	-	125,713	1.7%	2.5%	42
	Not Available	6,895	21.9%	-	2,377,989	32.4%	-	51
	Total	**31,547**	**100.0%**	**100.0%**	**7,334,734**	**100.0%**	**100.0%**	**57**
Children under age 18	Private Residence	5,008	78.0%	96.4%	1,242,259	61.0%	92.0%	56
	Foster Home	81	1.3%	1.6%	46,357	2.3%	3.4%	47
	Residential Care	54	0.8%	1.0%	16,035	0.8%	1.2%	42
	Crisis Residence	-	-	-	1,539	0.1%	0.1%	26
	Residential Treatment Center	-	-	-	5,600	0.3%	0.4%	31
	Institutional Setting	13	0.2%	0.3%	6,974	0.3%	0.5%	44
	Jail (Correctional Facility)	1	0.0%	0.0%	5,227	0.3%	0.4%	45
	Homeless (Shelter)	36	0.6%	0.7%	7,719	0.4%	0.6%	49
	Other	-	-	-	17,890	0.9%	1.3%	39
	Not Available	1,226	19.1%	-	685,914	33.7%	-	47
	Total	**6,419**	**100.0%**	**100.0%**	**2,035,514**	**100.0%**	**100.0%**	**57**
Adults age 18 and older	Private Residence	16,096	64.1%	82.7%	2,953,698	56.2%	82.0%	57
	Foster Home	19	0.1%	0.1%	15,056	0.3%	0.4%	45
	Residential Care	1,368	5.4%	7.0%	157,103	3.0%	4.4%	52
	Crisis Residence	-	-	-	6,949	0.1%	0.2%	28
	Residential Treatment Center	-	-	-	3,538	0.1%	0.1%	24
	Institutional Setting	143	0.6%	0.7%	82,906	1.6%	2.3%	51
	Jail (Correctional Facility)	102	0.4%	0.5%	66,979	1.3%	1.9%	51
	Homeless (Shelter)	1,731	6.9%	8.9%	208,974	4.0%	5.8%	52
	Other	-	-	-	107,690	2.0%	3.0%	42
	Not Available	5,669	22.6%	-	1,654,263	31.5%	-	50
	Total	**25,128**	**100.0%**	**100.0%**	**5,257,156**	**100.0%**	**100.0%**	**57**

This table uses data from URS Table 15.

State Notes:

Age calculated at midpoint of reporting period. Populated by NRI using Rhode Island's 2020 MH CLD-BCI dataset.

APPROPRIATENESS DOMAIN: Persons Who were Homeless by Age, Gender, Race, and Ethnicity, FY 2020

STATE: Rhode Island

Reporting Period: 7/1/2019 To: 6/30/2020

	Homeless or Living in Shelters				Percent of Total with Known Living Situation		
	State		US		State	US	States
Demographic	N	%	N	%	%	%	Reporting
Age 0 to 17	36	2.0%	7,719	3.6%	0.7%	0.6%	49
Age 18 to 64	1,683	95.2%	203,079	93.7%	9.5%	6.1%	52
Age 65+	48	2.7%	5,895	2.7%	2.9%	2.2%	49
Age Not Available	-	-	38	0.0%	-	0.9%	9
Age Total	**1,767**	**100.0%**	**216,731**	**100.0%**	**7.2%**	**4.4%**	**52**
Female	640	36.2%	85,801	39.6%	5.1%	3.3%	52
Male	1,127	63.8%	130,307	60.1%	9.3%	5.5%	51
Gender Not Available	-	-	623	0.3%	-	9.9%	20
Gender Total	**1,767**	**100.0%**	**216,731**	**100.0%**	**7.2%**	**4.4%**	**52**
American Indian or Alaska Native	27	1.5%	5,474	2.5%	14.7%	6.3%	47
Asian	4	0.2%	2,015	0.9%	1.7%	2.7%	45
Black or African American	310	17.5%	64,744	29.9%	10.7%	7.0%	49
Native Hawaiian or Other Pacific Islander	3	0.2%	724	0.3%	5.0%	6.5%	38
White	1,117	63.2%	110,460	51.0%	6.6%	3.7%	48
More Than One Race	127	7.2%	7,206	3.3%	13.3%	3.7%	47
Race Not Available	179	10.1%	26,108	12.0%	5.3%	3.9%	46
Race Total	**1,767**	**100.0%**	**216,731**	**100.0%**	**7.2%**	**4.4%**	**52**
Hispanic or Latino	299	16.9%	33,727	15.6%	5.6%	3.9%	50
Not Hispanic or Latino	1,308	74.0%	169,623	78.3%	7.7%	4.5%	50
Not Available	160	9.1%	13,381	6.2%	6.9%	4.2%	43
Ethnicity Total	**1,767**	**100.0%**	**216,731**	**100.0%**	**7.2%**	**4.4%**	**52**

Note:

US totals are based on states reporting.

This table uses data from URS Table 15.

US totals are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.

State Notes:

Age calculated at midpoint of reporting period. Populated by NRI using Rhode Island's 2020 MH CLD-BCI dataset.

Appropriateness Domain: Evidence-Based Practices Reported by SMHAs, FY 2020

Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Adult EBP Services	State		US		Penetration Rate: % of Consumers Receiving EBP/Estimated SMI		Measuring Fidelity		States Reporting
	EBP N	SMI N	EBP N	SMI N	State	US Average	State	US	
Supported Housing	152	20,280	70,648	3,854,379	0.7%	2.3%	No	8	30
Supported Employment	733	20,280	66,662	3,854,379	3.6%	1.9%	No	20	41
Assertive Community Treatment	1,801	20,280	66,159	3,854,379	8.9%	1.8%	-	24	42
Family Psychoeducation	-	-	37,873	3,854,379	-	3.1%	-	3	16
Dual Diagnosis Treatment	3,294	20,280	199,597	3,854,379	16.2%	9.5%	-	8	24
Illness Self Management	-	-	308,378	3,854,379	-	19.1%	-	4	22
Medication Management	3,216	20,280	545,051	3,854,379	15.9%	31.3%	No	1	21

Child/Adolescent EBP Services	State		US		Penetration Rate: % of Consumers Receiving EBP/Estimated SED		Measuring Fidelity		States Reporting
	EBP N	SED N	EBP N	SED N	State	US Average	State	US	
Therapeutic Foster Care	-	-	13,178	1,312,014	-	1.7%	-	4	21
Multi-Systemic Therapy	-	-	31,303	1,312,014	-	4.1%	-	8	20
Family Functional Therapy	-	-	31,817	1,312,014	-	5.8%	-	6	15

Note:

US totals are based on states reporting.

This table uses data from URS Tables 16 and 17.

US averages are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.

State Notes:

Table 16: DCYF is the state authority for children's mental health. Currently, they do not collect data on children with SED. This is something they are working on tracking in the future.

Table 17: None

Appropriateness Domain: Adults with SMI and Children with SED Receiving Evidence-Based Services for First Episode Psychosis (FEP), 2020

Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Number of coordinated specialty care programs: 2

Admissions to Coordinated Specialty Care (CSC)-FEP Service During the Year

	State		US		
	N	%	N	%	States Reporting
Adult CSC-FEP Admissions	130	88.4%	15,544	62.7%	45
Children/Adolescent CSC-FEP Admissions	17	11.6%	9,228	37.3%	41
Total CSC-FEP Admissions	147	100.0%	24,772	100.0%	46
Total Programs Reporting Number of Admissions	2	100.0%	287	88.0%	47
Average Admissions per Program	73.5	-	76.0	-	46

Clients Currently Receiving CSC-FEP Services

	State		US		
	N	%	N	%	States Reporting
Adults Receiving CSC-FEP Services	60	88.2%	15,470	85.8%	45
Children/Adolescents Receiving CSC-FEP Services	8	11.8%	2,557	14.2%	43
Total Receiving CSC-FEP Services	68	100.0%	18,027	100.0%	46
Total Programs Reporting Number of Clients Receiving Services	2	100.0%	292	89.6%	47
Average Number of Clients Services per Program	34.0	-	55.3	-	46

CSC-FEP Fidelity and Training

	State		US		
	N	%	N	%	States Reporting
Number of Programs Measuring Fidelity	2	100.0%	177	54.3%	46
Number of Programs with Staff Training Specifically in CSC EBP	2	100.0%	275	84.4%	41

Clients Served by Programs With and Without CSC-FEP Fidelity

	State			US			
	Number of Programs	Clients Served	Average Number of Clients Served Per Program	Number of Programs	Clients Served	Average Number of Clients Served Per Program	States Reporting
Programs with Fidelity	2	68	34.00	177	11,736	66.31	34
Programs without Fidelity	-	-	-	149	6,291	42.22	19

Note: This table use data from URS Table 16a.

Outcomes Domain: Employment Status of Adult Mental Health Consumers Served in the Community by Age and Gender, FY 2020

Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Demographics	State				Employed as Percent of those in Labor Force		Employed as Percent of Known Employment Status		States Reporting
	Employed	Unemployed	In Labor Force*	With Known Employment Status**	State	US	State	US	
Age 18 to 20	179	236	415	1,265	43%	50%	14.2%	22.3%	56
Age 21 to 64	3,686	5,457	9,143	15,911	40%	47%	23.2%	25.0%	57
Age 65 and over	87	202	289	1,652	30%	40%	5.3%	10.9%	57
Age Not Available	-	-	-	-	-	41%	-	13.7%	8
Age TOTAL	3,952	5,895	9,847	18,828	40%	47%	21.0%	23.6%	57
Female	2,051	2,903	4,954	9,979	41%	50%	20.6%	24.7%	57
Male	1,901	2,992	4,893	8,848	39%	44%	21.5%	22.3%	57
Gender Not Available	-	-	-	1	-	49%	0.0%	28.8%	30
Gender TOTAL	3,952	5,895	9,847	18,828	40%	47%	21.0%	23.6%	57

What populations are reported? All Clients Number of States Reporting All Clients: 44 Number of States Reporting Some Clients: 13

When is Employment Status Measured?	At Admission	At Discharge	Monthly	Quarterly	Other
RI	Yes	Yes	-	-	Semi-annual
US	36	25	3	7	25

Note:

*In Labor Force is the sum of consumers employed and unemployed.

**With Known Employment Status is the sum of consumer employed, unemployed and not in labor force.

Consumers employed as a % of those in labor force uses adults employed and unemployed as the denominator.

Consumers employed as % of known employment status uses the sum of persons employed, unemployed and not in labor force as the denominator.

This table uses data from URS Table 4.

State Notes:

Age	Age calculated at midpoint of reporting period
Gender	None
Overall	Populated by NRI using Rhode Island's 2020 MH CLD-BCI dataset.

Outcomes Domain: Employment Status of Adult Mental Health Consumers Served in the Community by Diagnosis, FY 2020

Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Diagnosis	State				Employed as a % of Labor Force		Employed as % of Known Employment Status		% of Consumers with Dx		States Reporting
	Employed	Unemployed	In Labor Force*	With Known Employment Status**	State	US	State	US	State	US	
Schizophrenia and Related Disorders	227	807	1,034	2,614	22.0%	30.2%	8.7%	9.9%	13.9%	13.9%	52
Bipolar and Mood Disorders	1,855	3,201	5,056	9,878	36.7%	47.4%	18.8%	24.3%	52.5%	40.1%	52
Other Psychoses	57	142	199	408	28.6%	31.2%	14.0%	13.3%	2.2%	2.2%	51
All other Diagnoses	1,267	1,178	2,445	4,222	51.8%	52.5%	30.0%	28.6%	22.4%	36.9%	52
No Diagnosis and Deferred Diagnosis	546	567	1,113	1,706	49.1%	49.3%	32.0%	27.0%	9.1%	6.8%	42
TOTAL	3,952	5,895	9,847	18,828	40.1%	47.7%	21.0%	23.8%	100.0%	100.0%	52

Note:

*In Labor Force is the sum of consumers employed and unemployed.

**With Known Employment Status is the sum of consumer employed, unemployed and not in labor force.

Consumers employed as a % of those in labor force uses adults employed and unemployed as the denominator.

Consumers employed as % of known employment status uses the sum of persons employed, unemployed and not in labor force as the denominator.

This table uses data for URS Table 4a.

State Notes:

Populated by NRI using Rhode Island's 2020 MH CLD-BCI dataset.

CONSUMER SURVEY RESULTS, FY 2020

Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Indicators	Children: State	Children: U.S. Average	States Reporting	Adults: State	Adults: U.S. Average	States Reporting
Reporting Positively About Access	-	89.2%	46	95.0%	88.9%	49
Reporting Positively About Quality and Appropriateness				94.7%	90.8%	48
Reporting Positively About Outcomes	-	74.6%	45	74.5%	79.6%	49
Reporting on Participation in Treatment Planning	-	89.4%	46	94.5%	86.9%	47
Family Members Reporting High Cultural Sensitivity of Staff	-	94.6%	43			
Reporting positively about General Satisfaction with Services	-	89.2%	47	92.6%	90.1%	48

Note: U.S. Average Children & Adult rates are calculated only for states that used a version of the MHSIP Consumer Survey

This table uses data from URS Table 11.

Children/Family	State	U.S.
Type of Survey Used		YSS-F=37

Type of Adult Consumer Survey Used	28-Item MHSIP	Other MHSIP	Other Survey
State	Yes	-	-
U.S.	31	16	4

Sample Size & Response Rate	Children: State	Children: U.S.	States Reporting	Adults: State	Adults: U.S. Average	States Reporting
Response Rate	-	99.6%	35	-	44.3%	35
Number of Surveys Attempted (send out)	-	165,134	36	-	229,432	34
Number of Surveys Contacts Made	-	109,930	35	-	172,014	35
Complete Surveys	-	42,210	40	-	84,692	40

Populations covered in survey	Children: State	Children: U.S.	Adults: State	Adults: U.S.
All Consumers	-	6	-	4
Sample	-	41	Yes	44

Sample Approach	Children: State	Children: U.S.	Adults: State	Adults: U.S.
Random Sample	-	8	-	8
Stratified Sample	-	14	-	15
Convenience Sample	-	17	-	18
Other Sample	-	2	Yes	3

Who is Sampled?	Children: State	Children: U.S.	Adults: State	Adults: U.S.
Current Clients	-	44	Yes	48
Former Clients	-	15	-	21

Populations included in sample: (e.g., all adults, only adults with SMI, etc.)	Children: State	Children: U.S.	Adults: State	Adults: U.S.
All Children or Adults Served	-	26	-	27
SMI Adults or SED Children	-	19	Yes	20
Persons Covered by Medicaid	-	13	Yes	11
Other	-	4	-	5

State Notes:
None

OUTCOMES DOMAIN: Consumer Survey Results, by Race/Ethnicity FY 2020

STATE: Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Race/Ethnicity	Family of Children Survey Indicators: Reporting Positively About...														States
	Access		General Satisfaction with Services		Outcomes		Participation In Tx Planning		Cultural Sensitivity of Staff		Social Connectedness		Improved Functioning		
	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	
American Indian or Alaska Native	-	80%	-	84%	-	71%	-	85%	-	91%	-	84%	-	69%	28
Asian	-	87%	-	90%	-	71%	-	90%	-	94%	-	85%	-	72%	22
Black or African American	-	92%	-	92%	-	78%	-	93%	-	96%	-	88%	-	70%	30
Native Hawaiian or Other Pacific Islander	-	87%	-	89%	-	76%	-	89%	-	89%	-	88%	-	75%	18
White	-	89%	-	89%	-	76%	-	92%	-	95%	-	89%	-	72%	34
Hispanic or Latino	-	90%	-	91%	-	76%	-	90%	-	95%	-	89%	-	75%	26
More Than One Race	-	89%	-	91%	-	74%	-	90%	-	96%	-	88%	-	73%	24
Not Available	-	88%	-	88%	-	73%	-	89%	-	94%	-	88%	-	73%	34

Race/Ethnicity	Adult Consumer Survey Indicators: Reporting Positively About...														States
	Access		Quality & Appropriateness		Outcomes		Participation In Tx Planning		General Satisfaction		Social Connectedness		Improved Functioning		
	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	
American Indian or Alaska Native	100%	85%	100%	89%	100%	73%	100%	83%	100%	88%	67%	71%	100%	74%	33
Asian	100%	90%	100%	91%	100%	74%	100%	85%	100%	91%	100%	75%	92%	73%	32
Black or African American	95%	91%	96%	94%	75%	83%	89%	90%	89%	93%	74%	75%	67%	75%	34
Native Hawaiian or Other Pacific Islander	50%	90%	33%	91%	33%	83%	33%	83%	-	90%	33%	78%	33%	82%	24
White	94%	89%	93%	92%	75%	77%	94%	88%	92%	91%	79%	71%	75%	73%	36
Hispanic or Latino	100%	89%	99%	90%	81%	78%	97%	88%	100%	91%	78%	75%	78%	76%	26
More Than One Race	100%	89%	100%	91%	94%	76%	94%	85%	94%	91%	78%	73%	83%	75%	27
Not Available	95%	87%	95%	89%	74%	73%	95%	85%	93%	89%	79%	73%	74%	72%	36

Notes:

This table uses data from URS Table 11a.

State Notes:

None

Outcomes Domain: Change in Social Connectedness and Functioning, FY 2020

Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Indicators	Children				Adults			
	State	US Average	US Median	States Reporting	State	US Average	US Median	States Reporting
Percent Reporting Improved Social Connectedness from Services	-	88.4%	87.3%	42	78.9%	79.2%	72.9%	46
Percent Reporting Improved Functioning from Services	-	75.3%	70.2%	42	74.0%	80.4%	73.2%	46

Note:

This table uses data from URS Table 9.

US State Averages and Medians are calculated only with states which used the recommended Social Connectedness and Functioning questions.

Adult Social Connectedness and Functioning Measures	State	US
Did you use the recommended new Social Connectedness Questions?	Yes	43
Did you use the recommended new Functioning Domain Questions?	Yes	44
Did you collect these as part of your MHSIP Adult Consumer Survey?	Yes	43

Children/Family Social Connectedness and Functioning Measures	State	US
Did you use the recommended new Social Connectedness Questions?	-	40
Did you use the recommended new Functioning Domain Questions?	-	41
Did you collect these as part of your YSS-F Survey?	-	40

State Notes:

None

OUTCOMES DOMAIN: Civil (Non Forensic) & Forensic Patients Readmission within 30 Days by Age, Gender, and Race, FY 2020

STATE: Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Demographic	Readmissions within 30 days to state psychiatric hospitals: "Civil" (Non-Forensic) Patients							Readmissions within 30 days to state psychiatric hospitals: Forensic Patients						
	State			US				State			US			
	Readmissions N	Discharges N	%	Readmissions N	Discharges N	%	States Reporting	Readmissions N	Discharges N	%	Readmissions N	Discharges N	%	States Reporting
Age 0 to 12	0	0	-	119	1,752	6.8%	12	0	0	-	1	74	1.4%	1
Age 13 to 17	0	0	-	390	5,233	7.5%	16	0	0	-	32	556	5.8%	7
Age 18 to 20	0	0	-	449	4,399	10.2%	27	0	1	0.0%	23	883	2.6%	10
Age 21 to 64	0	7	0.0%	5,644	61,278	9.2%	42	1	59	1.7%	920	23,728	3.9%	40
Age 65 to 74	0	3	0.0%	330	2,534	13.0%	34	0	0	-	69	930	7.4%	18
Age 75 and over	0	1	0.0%	76	779	9.8%	15	0	0	-	11	211	5.2%	5
Age Not Available	0	0	-	-	11	-	0	0	0	-	-	2	-	0
Age Total	**0**	**11**	**0.0%**	**7,008**	**75,986**	**9.2%**	**48**	**1**	**60**	**1.7%**	**1,056**	**26,384**	**4.0%**	**42**
Female	0	3	0.0%	2,864	30,203	9.5%	42	0	20	0.0%	284	5,656	5.0%	24
Male	0	8	0.0%	4,143	45,758	9.1%	44	1	40	2.5%	772	20,717	3.7%	40
Gender Not Available	0	0	-	1	25	4.0%	1	0	0	-	-	11	-	0
Gender Total	**0**	**11**	**0.0%**	**7,008**	**75,986**	**9.2%**	**48**	**1**	**60**	**1.7%**	**1,056**	**26,384**	**4.0%**	**42**
American Indian or Alaska Native	0	0	-	153	1,472	10.4%	13	0	0	-	10	357	2.8%	5
Asian	0	0	-	130	1,079	12.0%	20	0	2	0.0%	17	496	3.4%	9
Black or African American	0	0	-	1,410	17,456	8.1%	35	0	18	0.0%	383	9,387	4.1%	32
Native Hawaiian or Other Pacific Islander	0	0	-	35	325	10.8%	6	0	0	-	4	96	4.2%	4
White	0	10	0.0%	4,529	49,527	9.1%	44	0	31	0.0%	505	12,720	4.0%	35
More Than One Race	0	0	-	194	1,886	10.3%	20	0	0	-	17	568	3.0%	11
Race Not Available	0	1	0.0%	557	4,241	13.1%	20	1	9	11.1%	120	2,760	4.3%	18
Race Total	**0**	**11**	**0.0%**	**7,008**	**75,986**	**9.2%**	**48**	**1**	**60**	**1.7%**	**1,056**	**26,384**	**4.0%**	**42**
Hispanic or Latino	0	1	0.0%	704	8,387	8.4%	24	1	5	20.0%	233	3,731	6.2%	16
Not Hispanic or Latino	0	10	0.0%	6,083	63,800	9.5%	45	0	52	0.0%	777	21,040	3.7%	39
Not Available	0	0	-	221	3,799	5.8%	17	0	3	0.0%	46	1,613	2.9%	12
Ethnicity Total	**0**	**11**	**0.0%**	**7,008**	**75,986**	**9.2%**	**48**	**1**	**60**	**1.7%**	**1,056**	**26,384**	**4.0%**	**42**

Forensics included in "non forensic" data? No

Note:

US totals are based on states reporting.

This table uses data from URS Tables 20a and 20b.

State Notes:

None

OUTCOMES DOMAIN: Civil (Non Forensic) & Forensic Patients Readmission within 180 Days by Age, Gender, and Race, FY 2020

STATE: Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Demographic	Readmissions within 180 days to state psychiatric hospitals: "Civil" (Non-Forensic) Patients							Readmissions within 180 days to state psychiatric hospitals: Forensic Patients						
	State			US				State			US			
	Readmissions N	Discharges N	%	Readmissions N	Discharges N	%	States Reporting	Readmissions N	Discharges N	%	Readmissions N	Discharges N	%	States Reporting
Age 0 to 12	0	0	-	274	1,752	15.6%	14	0	0	-	1	74	1.4%	1
Age 13 to 17	0	0	-	895	5,233	17.1%	19	0	0	-	64	556	11.5%	7
Age 18 to 20	0	0	-	861	4,399	19.6%	31	0	1	-	65	883	7.4%	24
Age 21 to 64	0	7	0.0%	12,444	61,278	20.3%	49	1	59	1.7%	2,408	23,728	10.1%	45
Age 65 to 74	0	3	0.0%	509	2,534	20.1%	38	0	0	-	127	930	13.7%	28
Age 75 and over	0	1	0.0%	102	779	13.1%	18	0	0	-	19	211	9.0%	11
Age Not Available	0	0	-	-	11	-		0	0	-	-	2	-	
Age Total	**0**	**11**	**0.0%**	**15,085**	**75,986**	**19.9%**	**49**	**1**	**60**	**1.7%**	**2,684**	**26,384**	**10.2%**	**47**
Female	0	3	0.0%	6,022	30,203	19.9%	47	0	20	-	616	5,656	10.9%	38
Male	0	8	0.0%	9,060	45,758	19.8%	49	1	40	2.5%	2,068	20,717	10.0%	46
Gender Not Available	0	0	-	3	25	12.0%	1	0	0	-	-	11	-	
Gender Total	**0**	**11**	**0.0%**	**15,085**	**75,986**	**19.9%**	**49**	**1**	**60**	**1.7%**	**2,684**	**26,384**	**10.2%**	**47**
American Indian or Alaska Native	0	0	-	356	1,472	24.2%	21	0	0	-	31	357	8.7%	16
Asian	0	0	-	291	1,079	27.0%	28	0	2	-	52	496	10.5%	18
Black or African American	0	0	-	3,370	17,456	19.3%	41	0	18	-	994	9,387	10.6%	38
Native Hawaiian or Other Pacific Islander	0	0	-	199	325	61.2%	8	0	0	-	12	96	12.5%	4
White	0	10	0.0%	9,647	49,527	19.5%	47	0	31	-	1,277	12,720	10.0%	44
More Than One Race	0	0	-	359	1,886	19.0%	25	0	0	-	60	568	10.6%	14
Race Not Available	0	1	0.0%	863	4,241	20.3%	29	1	9	11.1%	258	2,760	9.3%	22
Race Total	**0**	**11**	**0.0%**	**15,085**	**75,986**	**19.9%**	**49**	**1**	**60**	**1.7%**	**2,684**	**26,384**	**10.2%**	**47**
Hispanic or Latino	0	1	0.0%	1,512	8,387	18.0%	36	1	5	20.0%	441	3,731	11.8%	23
Not Hispanic or Latino	0	10	0.0%	12,990	63,800	20.4%	46	0	52	-	2,117	21,040	10.1%	43
Not Available	0	0	-	583	3,799	15.3%	24	0	3	-	126	1,613	7.8%	17
Ethnicity Total	**0**	**11**	**0.0%**	**15,085**	**75,986**	**19.9%**	**49**	**1**	**60**	**1.7%**	**2,684**	**26,384**	**10.2%**	**47**

Forensics included in "non forensic" data? No

Note:

US totals are based on states reporting.

This table uses data from URS Tables 20a and 20b.

State Notes:

None

Structure Domain: SMHA Expenditure for Early Serious Mental Illness and First Episode Psychosis, 2020

Rhode Island Reporting Period 7/1/2019 To: 6/30/2020

Activity	State								US							
	MHBG		Other Funds		State Funds		Total		MHBG		Other Funds		State Funds		Total	
	$	%	$	%	$	%	$	%	$	%	$	%	$	%	$	%
CSC-Evidence-Based Practices for First Episode Psychosis	$160,279	21.3%	$591,197	19.7%	$0	0.0%	$751,476	100%	$63,948,992	79.2%	$4,342,422	1.3%	$12,426,479	15.4%	$80,717,893	100%
Training for CSC Practices	$0	-	$0	-	$0	-	$0	-	$2,784,946	85.2%	$86,291	0.7%	$398,342	12.2%	$3,269,579	100%
Planning for CSC Practices	$0	-	$0	-	$0	-	$0	-	$618,403	63.5%	$56,517	1.5%	$299,052	30.7%	$973,972	100%
Other Early Serious Mental Illnesses program (other than FEP or partial CSC programs)	$0	-	$0	-	$0	-	$0	-	$5,407,541	97.8%	$96,351	0.4%	$25,000	0.5%	$5,528,892	100%
Training for ESMI	$0	-	$0	-	$0	-	$0	-	$730,894	93.5%	$26,106	0.8%	$25,000	3.2%	$782,000	100%
Planning for ESMI	$0	-	$0	-	$0	-	$0	-	$848,298	94.3%	$25,909	0.7%	$25,000	2.8%	$899,207	100%

Note: This table use data from URS Table 7a.

* Other Funds include Medicaid, Other Federal funds, local funds, and other funds from table 7a.

State Notes:

The decrease in EBP for ESMI expenditures from 2019 to 2020 is a result of change in contract as well as ending of Healthy Transtions grant.

STRUCTURE DOMAIN: State Mental Health Agency Controlled Expenditures for Mental Health, FY 2020

Rhode Island

Reporting Period: 7/1/2019 To: 6/30/2020

	Expenditures: State	Percent of Total Expenditures: State	Expenditures: U.S.	Percent of Total Expenditures: U.S.	States Reporting
State Hospitals-Inpatient	$8,893,945	12%	$12,020,465,152	26%	55
Other 24-Hour Care	-	0%	$5,901,357,290	13%	47
Ambulatory/Community	$61,881,319	83%	$25,997,107,370	57%	59
EBPs for Early Serious Mental Illness	$751,476	1%	$93,605,917	0%	59
Primary Prevention	-	0%	$51,669,494	0%	14
Other Psychiatric Inpatient Care	-	0%	$637,559,033	1%	16
Administration	$2,684,899	4%	$1,199,824,347	3%	55
Total	**$74,211,639**	**100%**	**$45,901,588,603**	**100%**	**59**

Note:

This table uses data from URS Table 7

State Notes:

For State hospital Medicaid spending, the amount has decreased so much from FY19 because the hospital stopped billing Medicaid after August 2019.

STRUCTURE DOMAIN: State Mental Health Agency Controlled Expenditures by Funding Sources, 2020

Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Funding Source	Ambulatory/Community			State Hospital		
	State	Percent Total (State)	Percent Total (US)	State	Percent Total (State)	Percent Total (US)
Mental Health Block Grant	$1,937,391	3.1%	1.8%	-	-	-
Medicaid (Federal, State, and Local)	$55,309,800	88.3%	63.2%	$8,893,945	100.0%	16.1%
Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)	$5,387,804	8.6%	2.6%	-	-	2.5%
State Funds	-	-	23.7%	-	-	76.3%
Local Funds (excluding local Medicaid)	-	-	6.2%	-	-	1.7%
Other	-	-	2.5%	-	-	3.4%
Total	$62,632,795	100%	100%	$8,893,945	100%	100%

Note:

This table uses data from URS Table 7

Ambulatory/Community includes Primary Prevention, Evidence-Based Practices for Early Serious Mental Illness, and Other 24-Hour Care expenditures

This table does not show expenditures for state central office including Research, Training, and Administration expenses.

State Notes:

For State hospital Medicaid spending, the amount has decreased so much from FY19 because the hospital stopped billing Medicaid after August 2019.

Structure Domain: Federal Mental Health Block Grant Expenditures for Non-Direct Service Activities, FY 2020

Rhode Island **Reporting Period:** 7/1/2019 To: 6/30/2020

Service	Non-Direct Block Grant Expenditures	% Total	US % Total
Information Systems	-	0.0%	4.7%
Infrastructure Support	-	0.0%	21.5%
Partnerships, community outreach, and needs assessment	$84,248	51.7%	28.7%
MHA Planning Council Activities	-	0.0%	2.4%
Quality assurance and improvement	-	0.0%	8.9%
Research and Evaluation	$22,760	14.0%	10.5%
Training and Education	$56,078	34.4%	23.3%
Total	$163,086	100.0%	100.0%

Note: This table use data from URS Table 8.

State Notes:

None

Structure Domain: Mental Health Programs Funded By the Federal Mental Health Block Grant, FY 2020

Rhode Island

Reporting Period: 7/1/2019 To: 6/30/2020

Adult Programs: 6	Child Programs: 1	Set-Aside FEP Programs: 2	Set-Aside ESMI Programs: 0	Total Programs: 8
Adult Total: $1,267,217	Child Total: $346,812	Set-Aside FEP Total: $160,279	Set-Aside ESMI Total: $0	Total: $2,109,504

Agency Name	Address	Area Served	Total Block Grant Funds	Block Grant for Adults with SMI	Block Grant for Children with SED	Set-Aside for FEP Programs	Set-Aside for ESMI Programs
Community Care Alliance	800 Clinton Street		$403,453	$0	$0	$68,257	$0
Horizon Health Partners	800 Clinton Street		$603,158	$603,158	$0	$0	$0
NAFI Connecticut	501 Centerville Road		$127,417	$127,417	$0	$0	$0
NAMI RI	154 Waterman Street		$109,721	$109,721	$0	$0	$0
Parent Support Network	535 Centerville Road		$280,317	$280,317	$0	$0	$0
DCYF	101 Friendship St		$346,812	$0	$346,812	$0	$0
Thrive Behavioral Health	2756 Post Road, Suite 200		$162,613	$70,591	$0	$92,022	$0
The Providence Center	528 North Main Street		$76,013	$76,013	$0	$0	$0

General Notes FY 2020

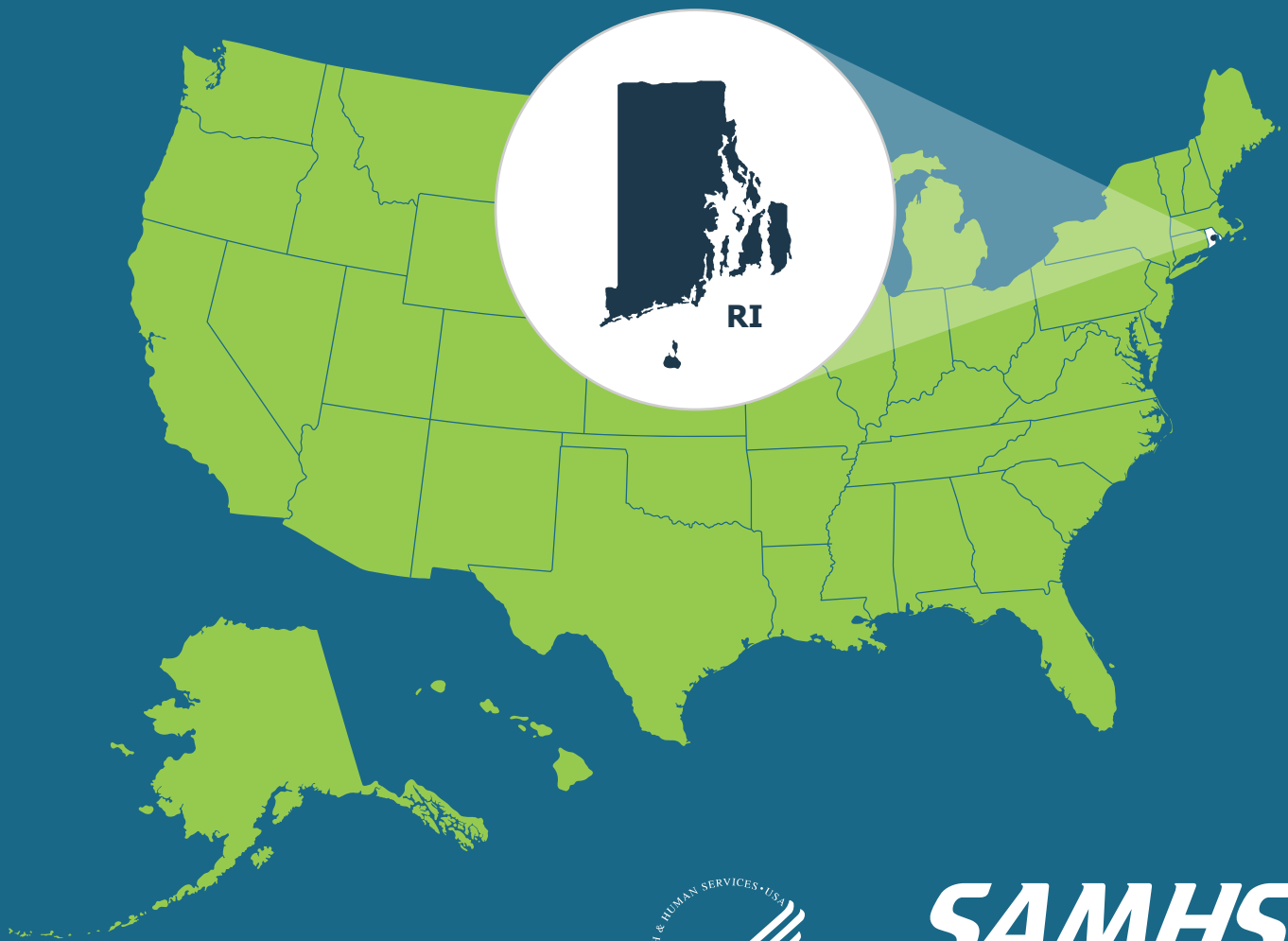
Rhode Island

URS Table Number	General Notes
6	We believe the decrease in admissinos to community programs from 2019 to 2020 is largely attributable to the COVID-19 pandemic. Upon further examination, we found that all programs in this category, but especially the lower acuity general outpatient program, saw a large drop in admissions in April, May, and June. In comparison, February and March of this year were comparable to last year, supporting this the theory that this drop is driven by the pandemic.
7	The decrease in other federal funds expenditures from 2019 to 2020 is a result of ending of federal grants that applied to FY19. The increase state expenditures from 2019 to 2020 are due to change in cost allocation plan. The decrease in expenditures for EBP for ESMI is a result of change in contracting with delays at start. The decrease in total expenditures from 2019 to 2020 is a result of reduction in overall budget that are explained by ending of federal grants, cost allocation plan changes/contracting changes.
7A	The decrease in EBP for ESMI expenditures from 2019 to 2020 is a result of change in contract as well as ending of Healthy Transtions grant.
8	The decrease in total non-direct MHBG expenditures from 2019 to 2020 is a result of shift in funding towards more direct services.
14A	The incrase in the numebr of multiracial clients is a result of better data entry.
16	Two of the five providers of Supported Housing services (including the largest provider) had issues with staffing and identifying consumers receiving Supported Housing Services. We are hoping to have updated numbers soon and will resubmit if they can get them, but for now, this metric should be considered incomplete.

Behavioral Health **Barometer**

Rhode Island, Volume 6

Indicators as measured through the 2019 National Survey on Drug Use and Health
and the National Survey of Substance Abuse Treatment Services



SAMHSA
Substance Abuse and Mental Health Services Administration

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Electronic Access

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Originating Office

Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857.

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Published 2020

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Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division within the U.S. Department of Health and Human Services (HHS), is charged with reducing the impact of substance abuse and mental illness on America's communities. SAMHSA is pursuing this mission at a time of significant change.

The *Behavioral Health Barometer: Rhode Island, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services* is one of a series of national, regional, and state reports that provide a snapshot of behavioral health in the United States. The reports present a set of substance use and mental health indicators as measured through the National Survey on Drug Use and Health (NSDUH) and the National Survey of Substance Abuse Treatment Services (N–SSATS), sponsored by SAMHSA.

This array of indicators provides a unique overview of the nation's behavioral health at a point in time as well as a mechanism for tracking changes over time. Behavioral Health Barometers for the nation, 10 regions, and all 50 states and the District of Columbia are published as part of SAMHSA's behavioral health quality improvement approach. Most importantly, the Behavioral Health Barometers provide critical information in support of SAMHSA's mission of reducing the impact of substance abuse and mental illness on America's communities.

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Introduction

Purpose of This Report

Behavioral Health Barometer: Rhode Island, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services provides an annual update on a series of topics that focus on substance use and mental health (collectively referred to as *behavioral health*) in the United States. SAMHSA selected specific topics and indicators in this report to represent a cross-section of the key behavioral health indicators that are assessed in SAMHSA data collections, including NSDUH and N–SSATS. This report is intended to provide a concise, reader-friendly summary of key behavioral health measures for lay and professional audiences.

Organization of This Report

This report is divided into sections based on content areas and age groups. It begins with sections on substance use, mental health, and mental health treatment among youth aged 12–17, followed by a section on substance use and mental health among young adults aged 18–25. Next are sections on substance use, misuse, use disorders, and treatment among youth and adults combined and on mental health and treatment among adults aged 18 or older. Figure titles are included above all graphics, including callouts for figure notes that are presented on pages 34–35. These figure notes include additional information about the measures, populations, and analyses presented in the graphics and text. Definitions of key measures and terms included in the report are presented on pages 36–37.

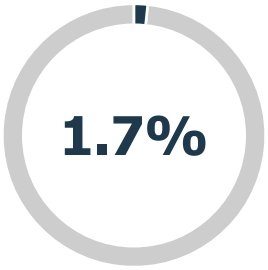
Methodological Information

Statistical tests (t-tests) have been conducted for all statements appearing in the text of the report based on NSDUH data that compare estimates between years or population subgroups. These tests properly account for the variances of each estimate being tested, as well as any joint variability (covariance) due to sample design or among non-mutually exclusive groups (e.g., each state is a subgroup of its respective region, and each region is a subgroup of the total United States). Positive covariance reduces the overall variance of the test statistic and may produce statistically significant results, even when the confidence intervals of each estimate overlap. Unless explicitly stated that a difference is not statistically significant, all statements based on NSDUH data that describe differences are significant at the .05 level. Standard NSDUH suppression rules have been applied for all NSDUH estimates in this report. Pages 27–30 present N–SSATS data, and because N–SSATS provides counts of people enrolled at all treatment facilities (as opposed to providing estimates based on a sample of treatment facilities), conducting significance tests is not necessary. Tables that display all data points included in this report, including tests of statistical significance and standard errors, are available upon request. To request these tables or to ask any questions regarding how to use or interpret the data included in this report, please contact CBHSQRequest@samhsa.hhs.gov.

Youth Substance Use

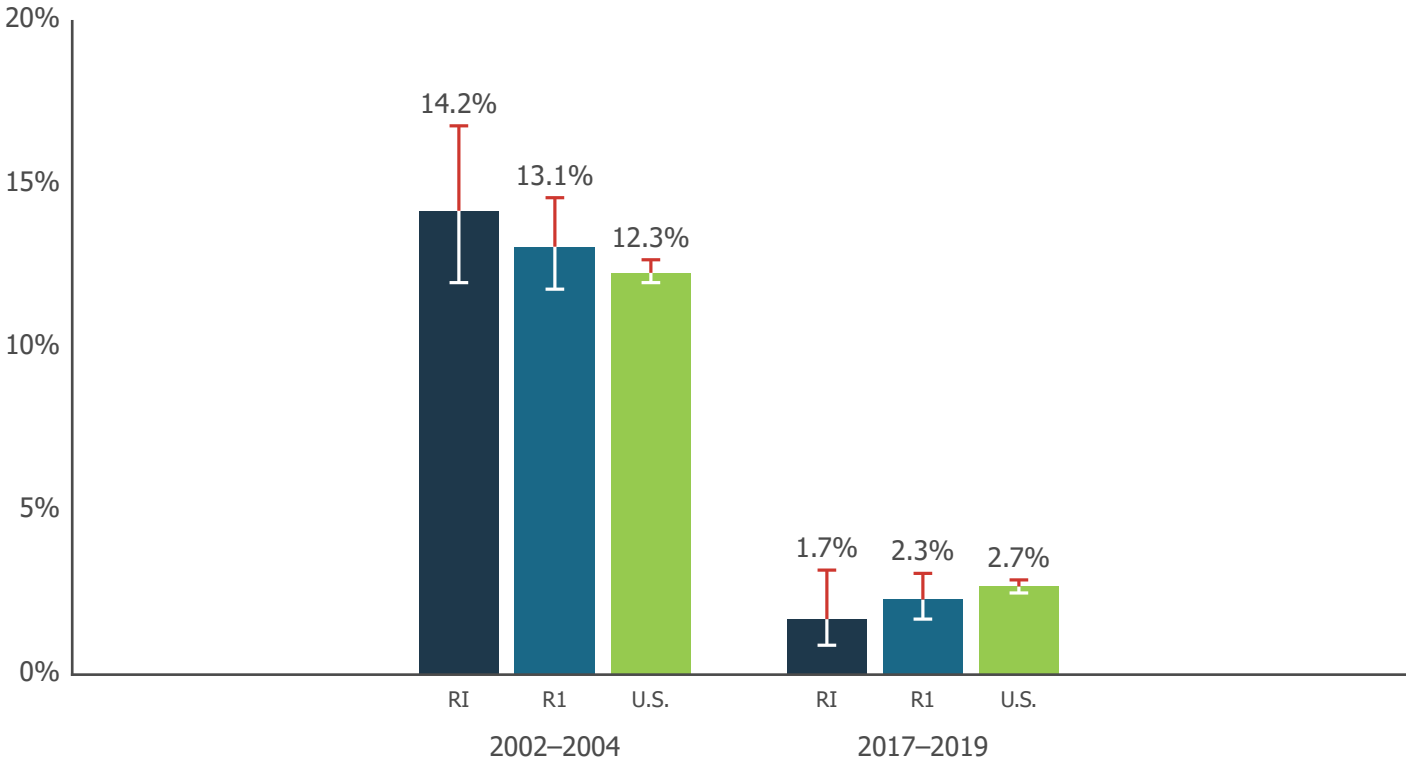
Cigarette Use

Changes in Past-Month Cigarette Use among Youth Aged 12–17 in Rhode Island, Region 1, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]



Among youth aged 12–17 in Rhode Island, the annual average percentage of cigarette use in the past month decreased between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-month cigarette use in Rhode Island was **1.7%** (or **1,000**), similar to both the regional average (**2.3%**) and the national average (**2.7%**).



Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

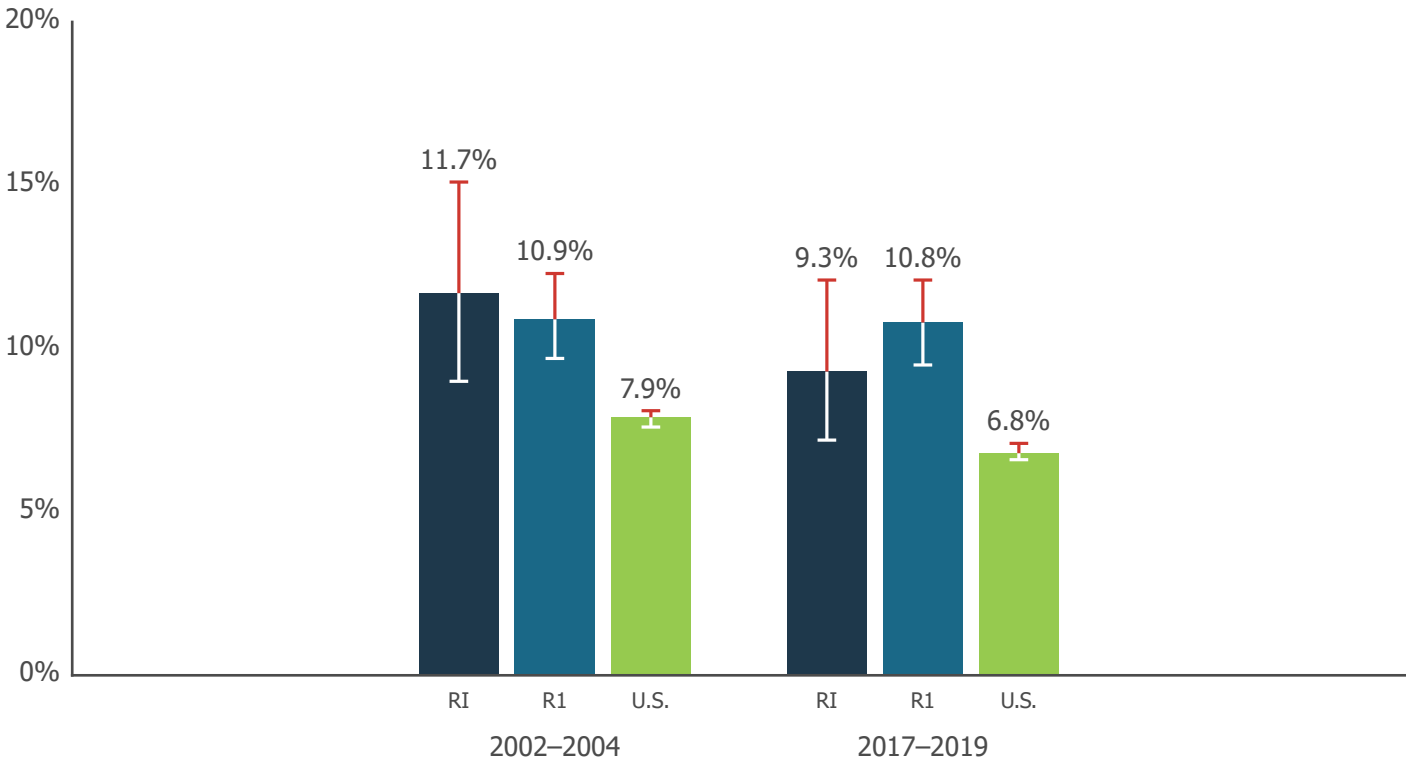
Youth Substance Use

Marijuana Use

Changes in Past-Month Marijuana Use among Youth Aged 12–17 in Rhode Island, Region 1, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]

Among youth aged 12–17 in Rhode Island, the annual average percentage of marijuana use in the past month did not significantly change between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-month marijuana use in Rhode Island was **9.3%** (or **7,000**), similar to the regional average (**10.8%**) but higher than the national average (**6.8%**).



Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

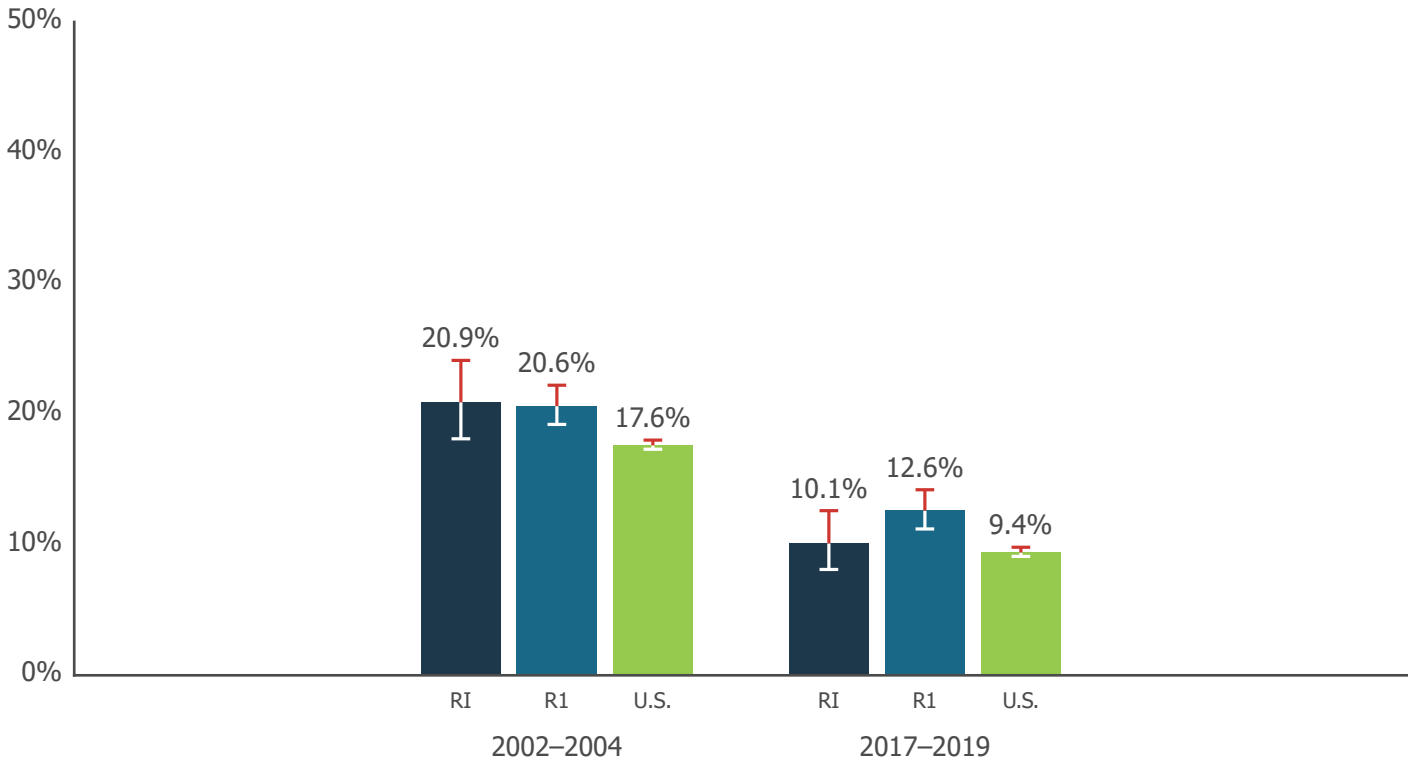
Youth Substance Use

Alcohol Use

Changes in Past-Month Alcohol Use among Youth Aged 12–17 in Rhode Island, Region 1, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]

Among youth aged 12–17 in Rhode Island, the annual average percentage of alcohol use in the past month decreased between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-month alcohol use in Rhode Island was **10.1%** (or **7,000**), similar to both the regional average (**12.6%**) and the national average (**9.4%**).



Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

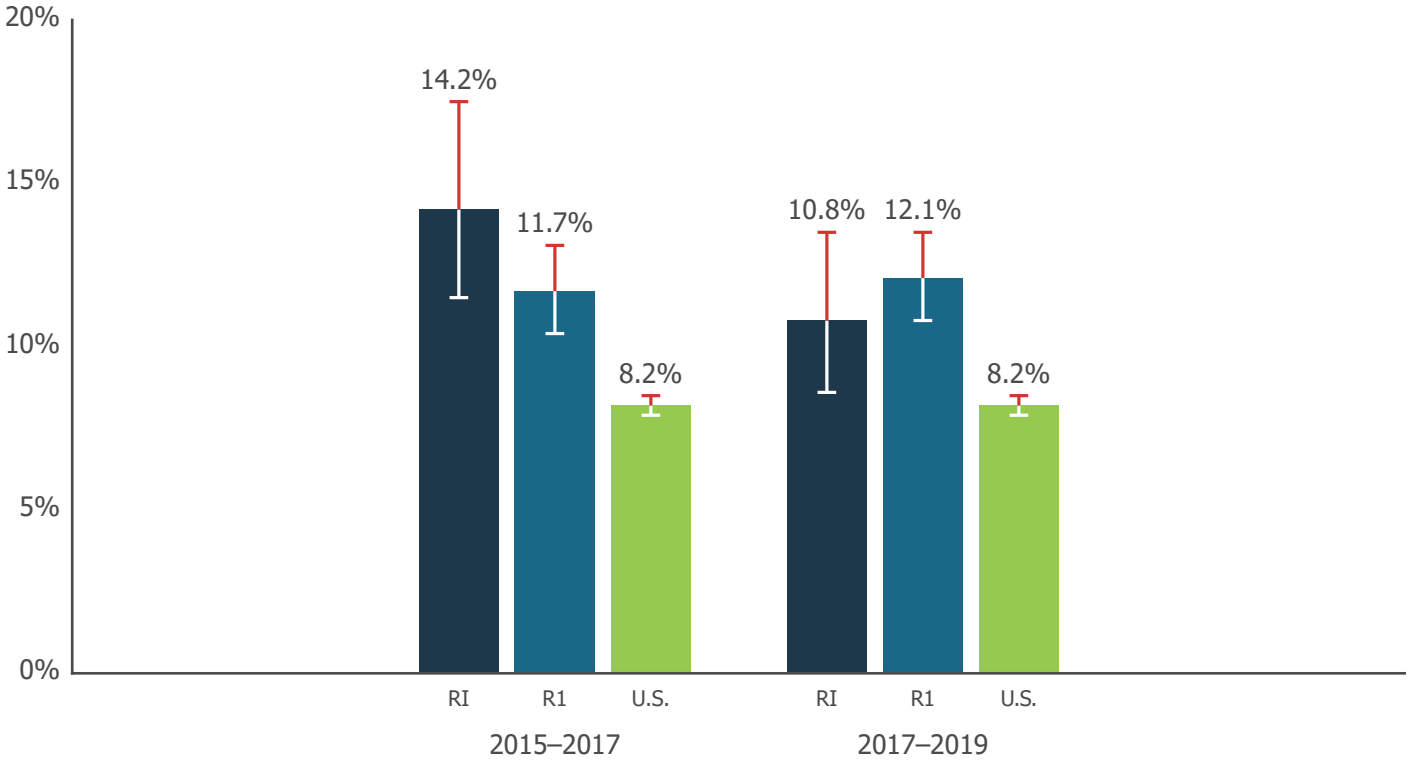
Youth Substance Use

Illicit Drug Use

Changes in Past-Month Illicit Drug Use among Youth Aged 12–17 in Rhode Island, Region 1, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1]

Among youth aged 12–17 in Rhode Island, the annual average percentage of illicit drug use in the past month did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-month illicit drug use in Rhode Island was **10.8%** (or **8,000**), similar to the regional average (**12.1%**) but higher than the national average (**8.2%**).



Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

Youth Substance Use

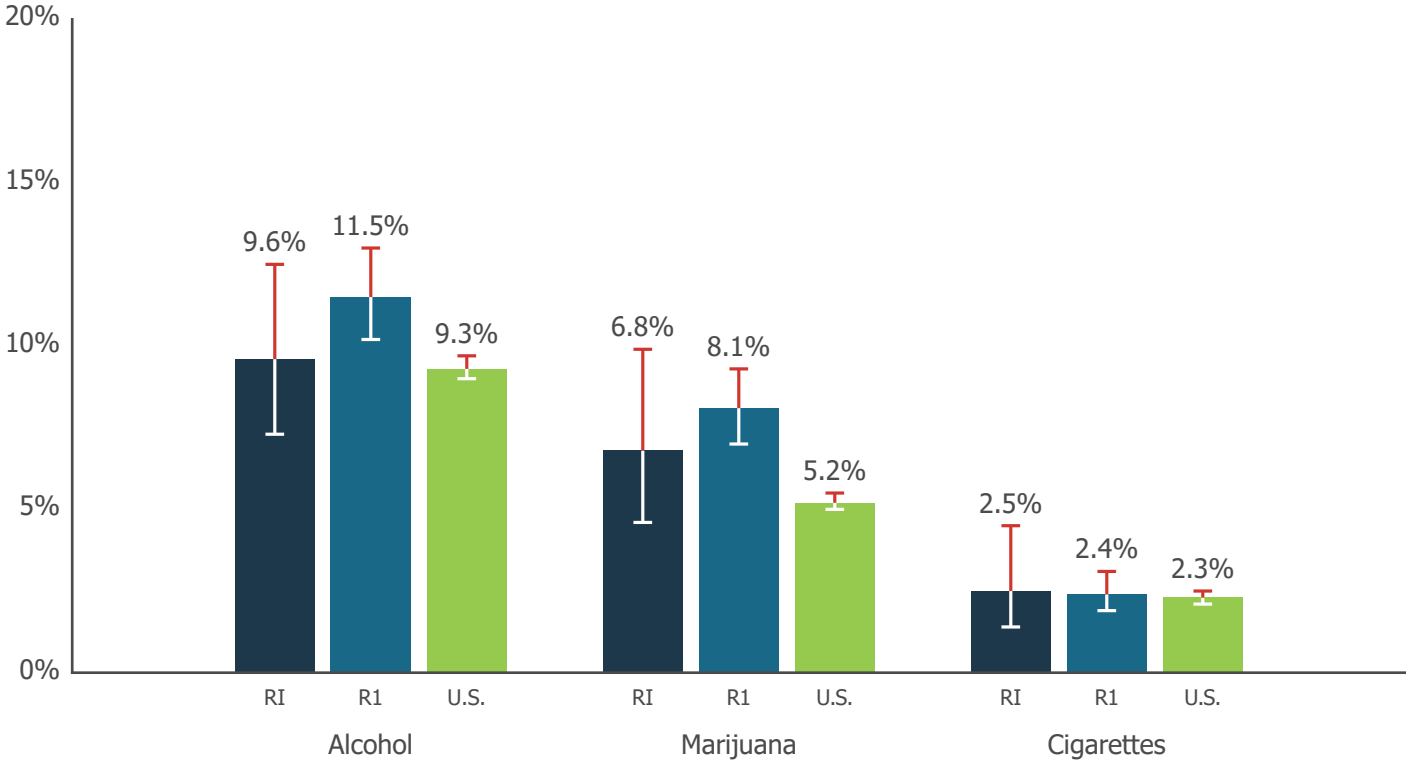
Initiation of Substance Use

Past-Year Initiation (First Lifetime Use) of Selected Substances among Youth Aged 12–17 in Rhode Island, Region 1, and the United States (Annual Average, 2017–2019)[1]

Among youth aged 12–17 in Rhode Island, during 2017–2019, an annual average of **9.6%** (or **7,000**) used alcohol for the first time in their lives, similar to both the regional average (**11.5%**) and the national average (**9.3%**).

In Rhode Island, an annual average of **6.8%** (or **5,000**) used marijuana for the first time in their lives, similar to both the regional average (**8.1%**) and the national average (**5.2%**).

In Rhode Island, an annual average of **2.5%** (or **2,000**) used cigarettes for the first time in their lives, similar to both the regional average (**2.4%**) and the national average (**2.3%**).



Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017–2019.

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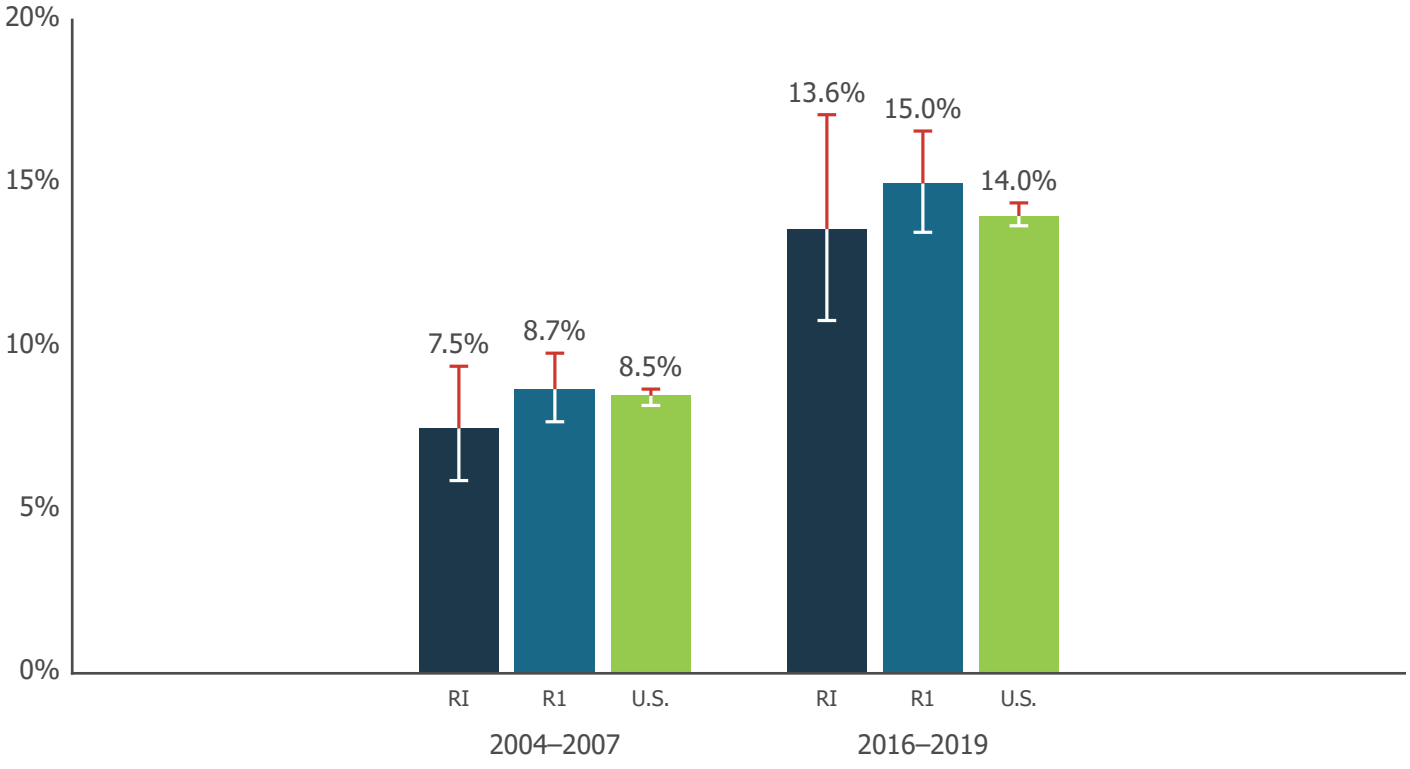
Youth Mental Health and Service Use

Depression

Changes in Past-Year Major Depressive Episode (MDE) among Youth Aged 12–17 in Rhode Island, Region 1, and the United States (Annual Averages, 2004–2007 and 2016–2019)[1,2]

Among youth aged 12–17 in Rhode Island, the annual average percentage with an MDE in the past year increased between 2004–2007 and 2016–2019.

During 2016–2019, the annual average prevalence of past-year MDE in Rhode Island was **13.6%** (or **10,000**), similar to both the regional average (**15.0%**) and the national average (**14.0%**).



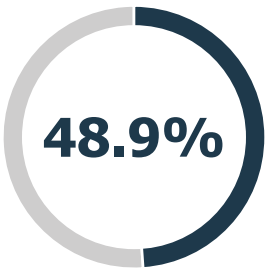
Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2004–2007 and 2016–2019.

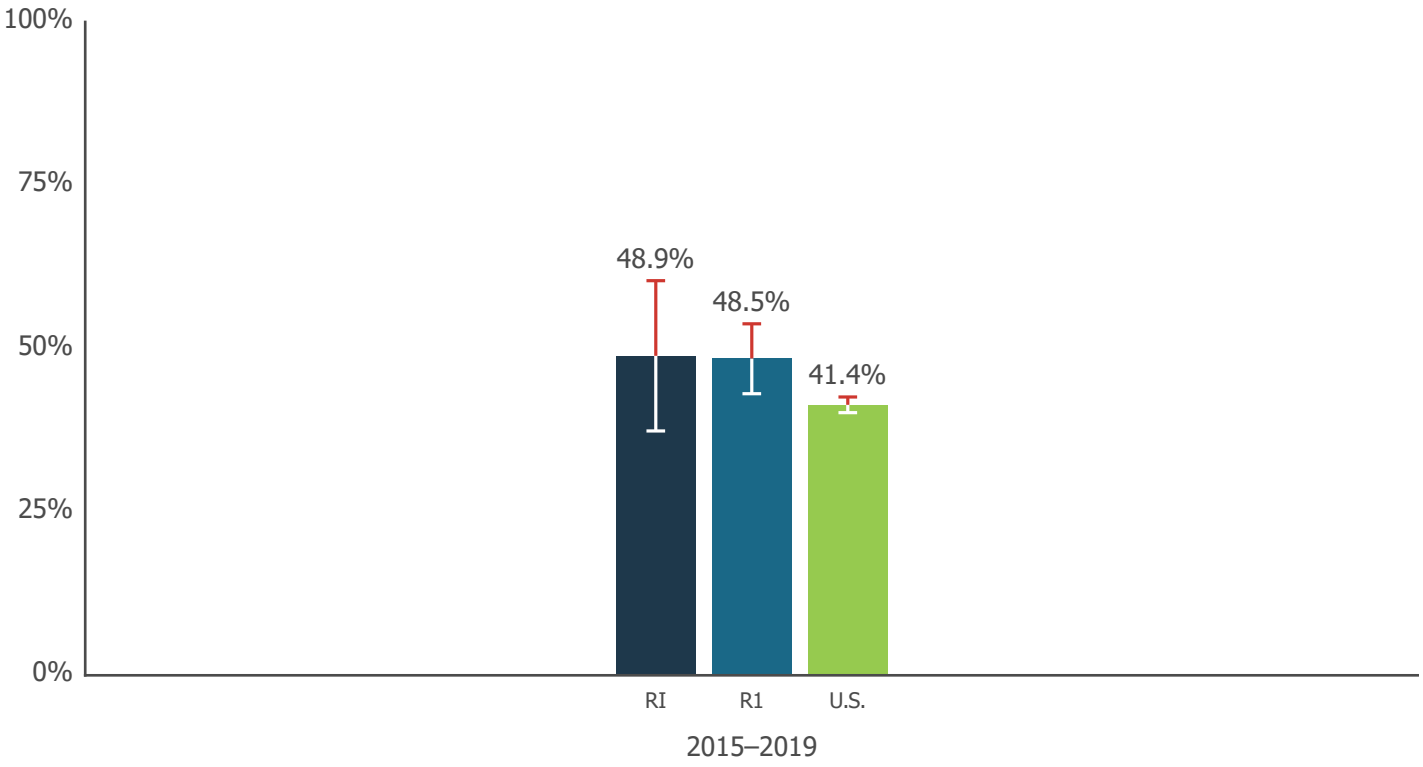
Youth Mental Health and Service Use

Depression Care

Past-Year Depression Care among Youth Aged 12–17 with Major Depressive Episode (MDE) in Rhode Island, Region 1, and the United States (Annual Average, 2015–2019)[1,3]



Among youth aged 12–17 in Rhode Island during 2015–2019 with an MDE in the past year, an annual average of **48.9%** (or **5,000**) received depression care in the past year, similar to both the regional average (**48.5%**) and the national average (**41.4%**).



Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

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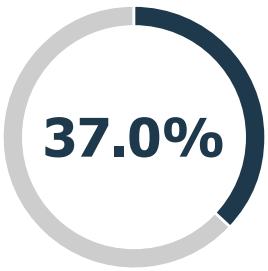
Young Adult Substance Use and Use Disorders

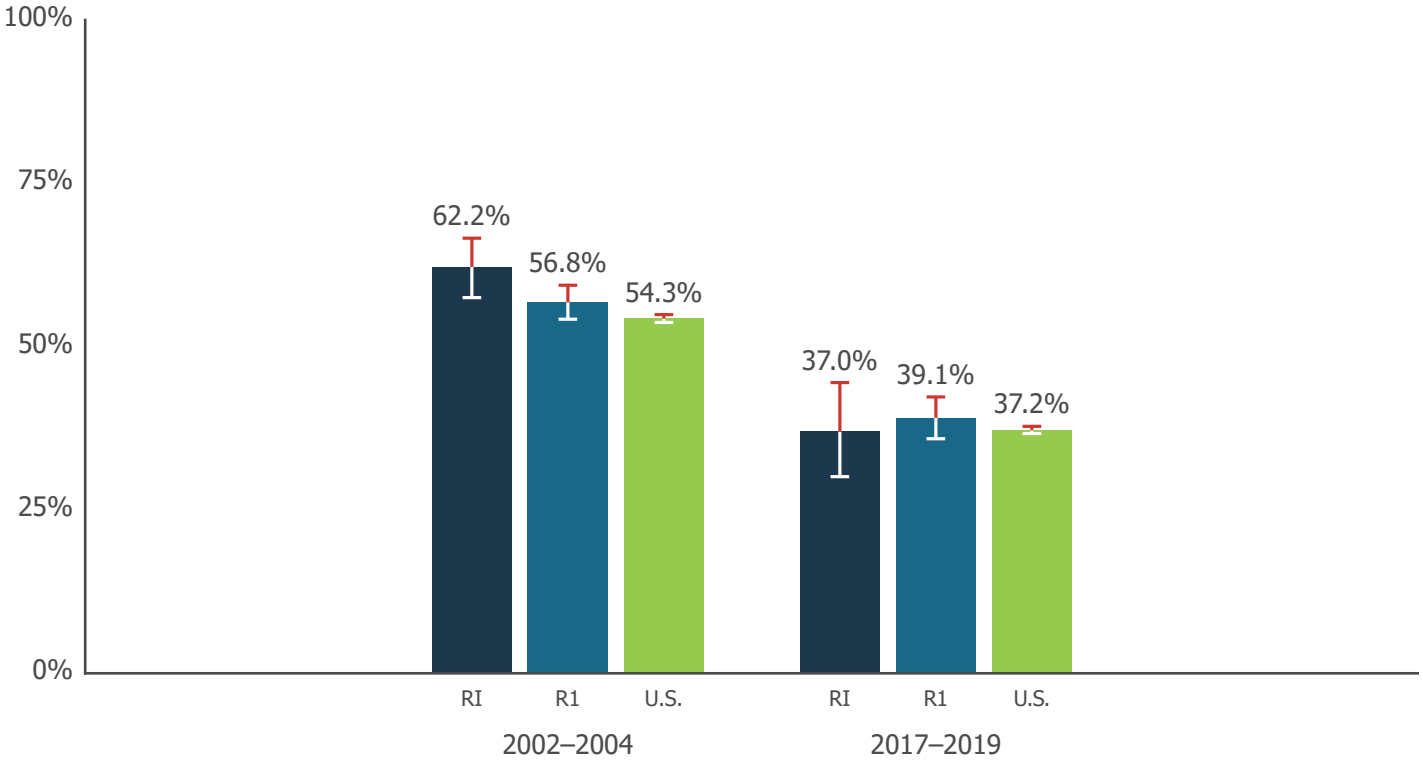
Tobacco Use

Changes in Past-Year Tobacco Use among Young Adults Aged 18–25 in Rhode Island, Region 1, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]



Among young adults aged 18–25 in Rhode Island, the annual average percentage of tobacco use in the past year decreased between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year tobacco use in Rhode Island was **37.0%** (or **46,000**), similar to both the regional average (**39.1%**) and the national average (**37.2%**).



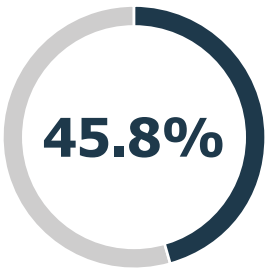
Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Young Adult Substance Use and Use Disorders

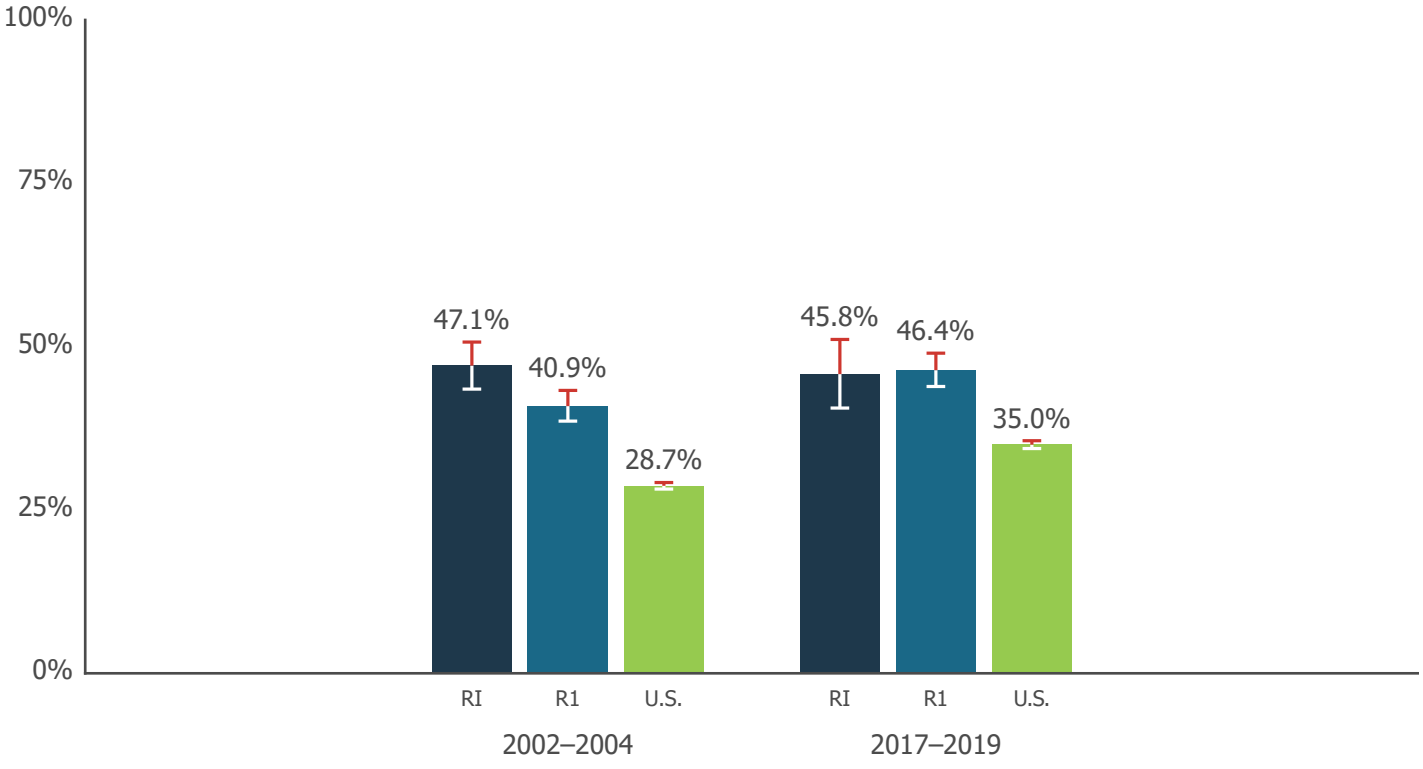
Marijuana Use

Changes in Past-Year Marijuana Use among Young Adults Aged 18–25 in Rhode Island, Region 1, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]



Among young adults aged 18–25 in Rhode Island, the annual average percentage of marijuana use in the past year did not significantly change between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year marijuana use in Rhode Island was **45.8%** (or **57,000**), similar to the regional average (**46.4%**) but higher than the national average (**35.0%**).



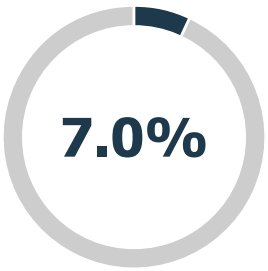
Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Young Adult Substance Use and Use Disorders

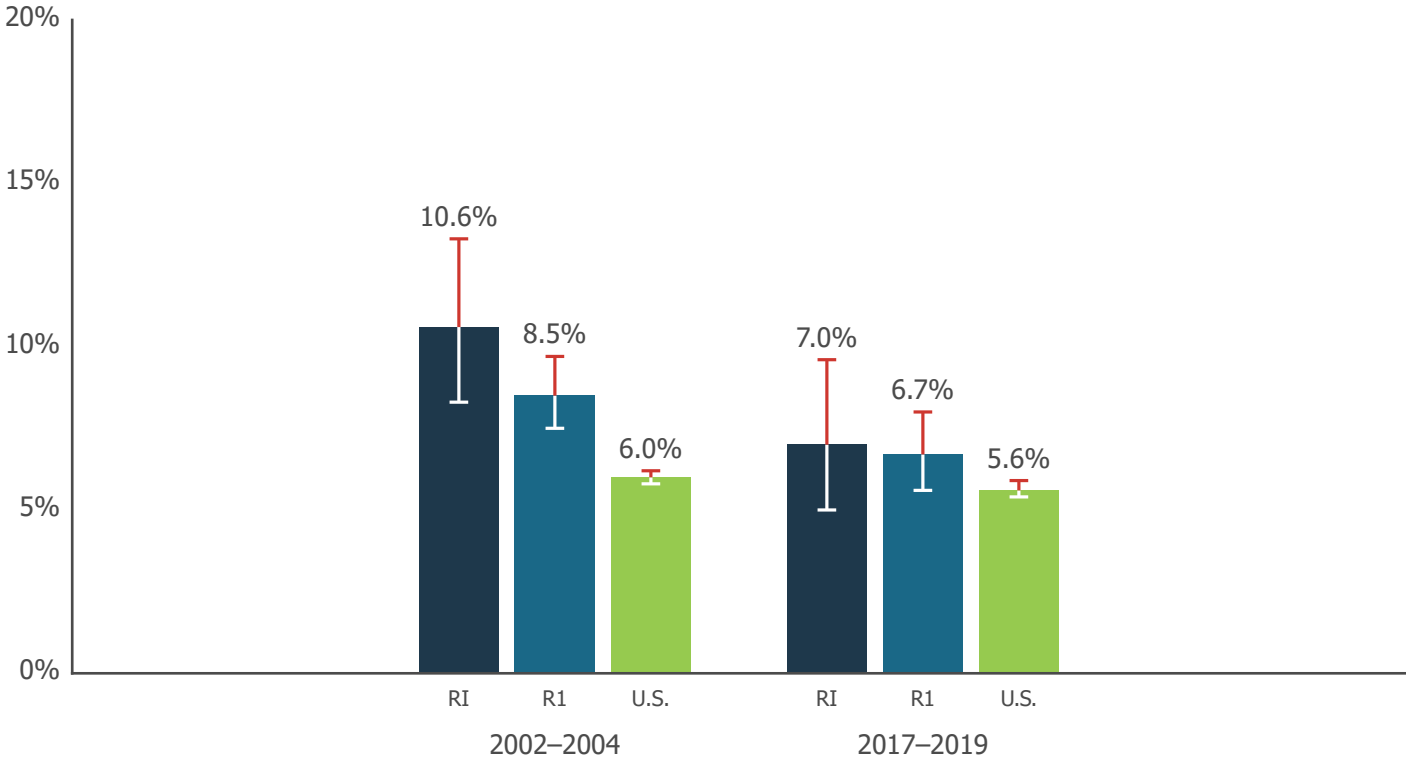
Marijuana Use Disorder

Changes in Past-Year Marijuana Use Disorder among Young Adults Aged 18–25 in Rhode Island, Region 1, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]



Among young adults aged 18–25 in Rhode Island, the annual average percentage of marijuana use disorder in the past year decreased between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year marijuana use disorder in Rhode Island was **7.0%** (or **9,000**), similar to both the regional average (**6.7%**) and the national average (**5.6%**).



Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

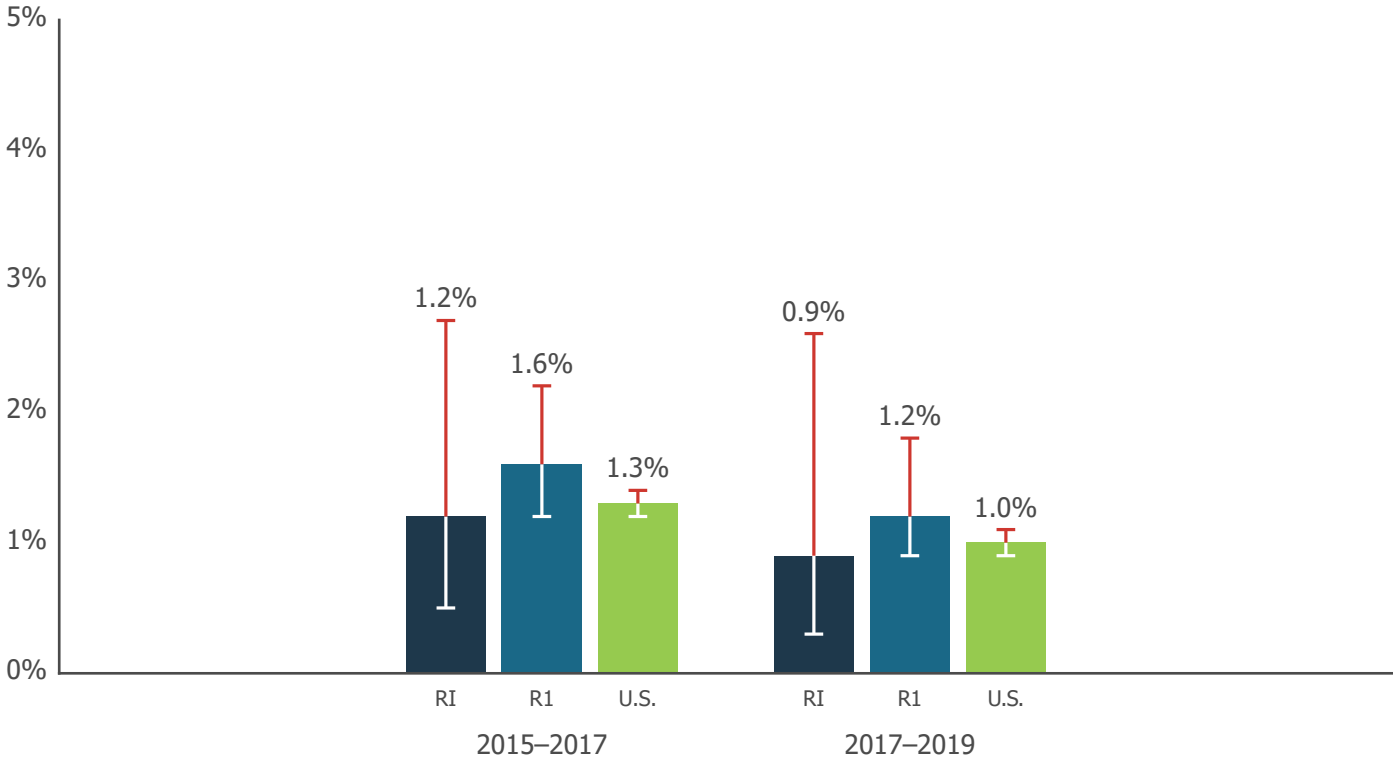
Young Adult Substance Use and Use Disorders

Opioid Use Disorder

Changes in Past-Year Opioid Use Disorder among Young Adults Aged 18–25 in Rhode Island, Region 1, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1]

Among young adults aged 18–25 in Rhode Island, the annual average percentage of opioid use disorder in the past year did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year opioid use disorder in Rhode Island was **0.9%** (or **1,000**), similar to both the regional average (**1.2%**) and the national average (**1.0%**).



Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

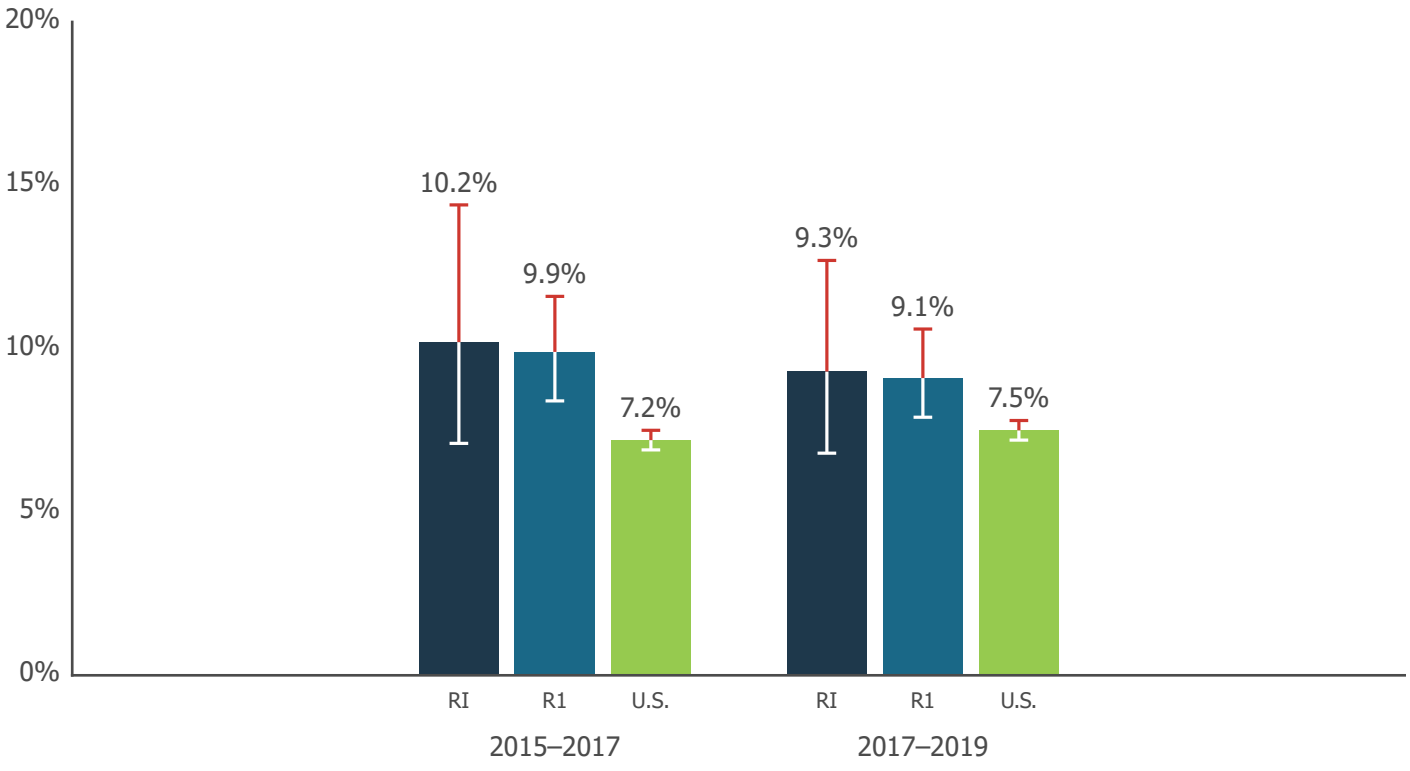
Young Adult Substance Use and Use Disorders

Illicit Drug Use Disorder

Changes in Past-Year Illicit Drug Use Disorder among Young Adults Aged 18–25 in Rhode Island, Region 1, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1]

Among young adults aged 18–25 in Rhode Island, the annual average percentage of illicit drug use disorder in the past year did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year illicit drug use disorder in Rhode Island was **9.3%** (or **12,000**), similar to both the regional average (**9.1%**) and the national average (**7.5%**).



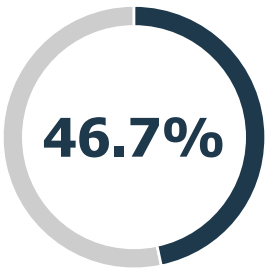
Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

Young Adult Substance Use and Use Disorders

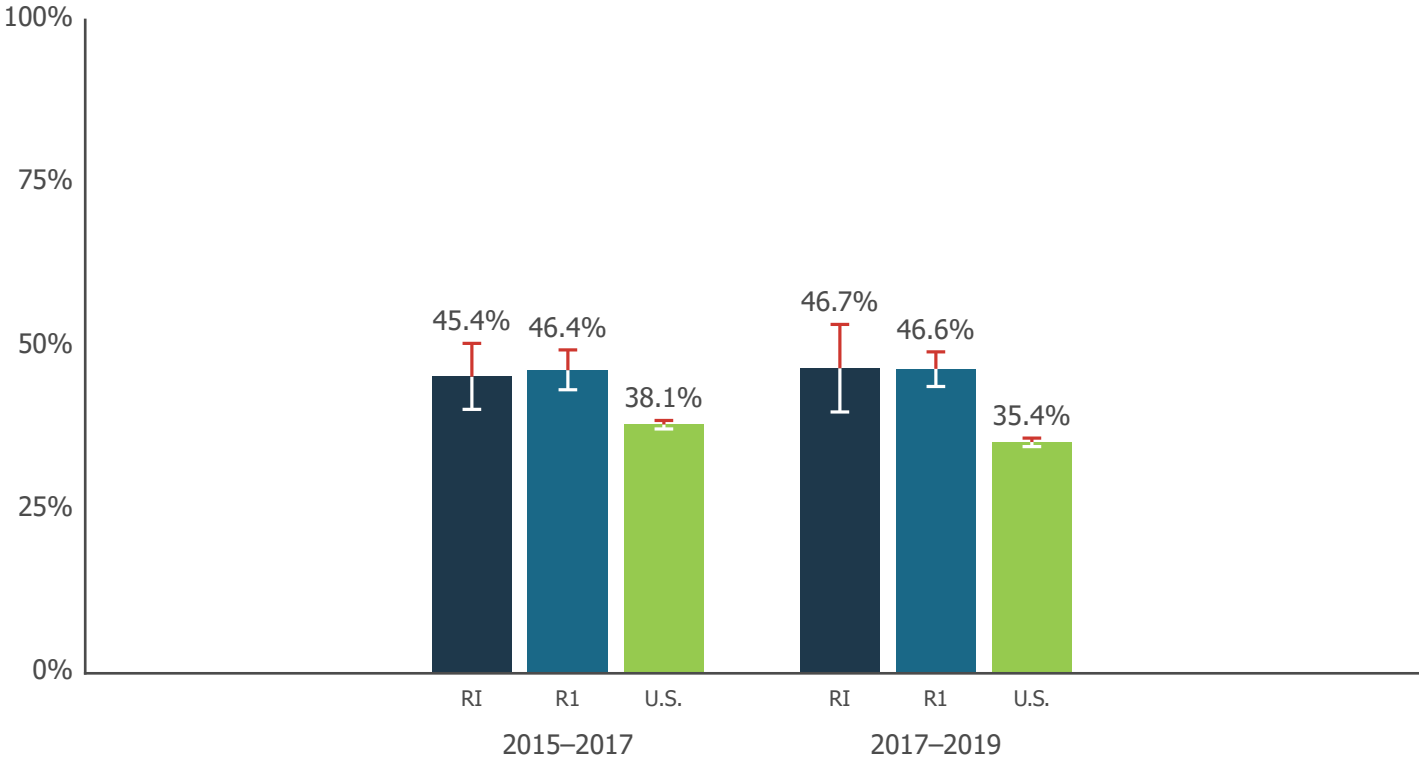
Binge Alcohol Use

Changes in Past-Month Binge Alcohol Use among Young Adults Aged 18–25 in Rhode Island, Region 1, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1,4]



Among young adults aged 18–25 in Rhode Island, the annual average percentage of binge alcohol use in the past month did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-month binge alcohol use in Rhode Island was **46.7%** (or **58,000**), similar to the regional average (**46.6%**) but higher than the national average (**35.4%**).



Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

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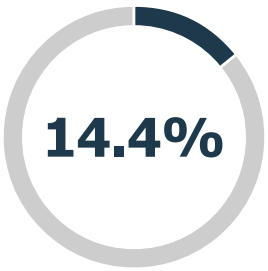
Young Adult Substance Use and Use Disorders

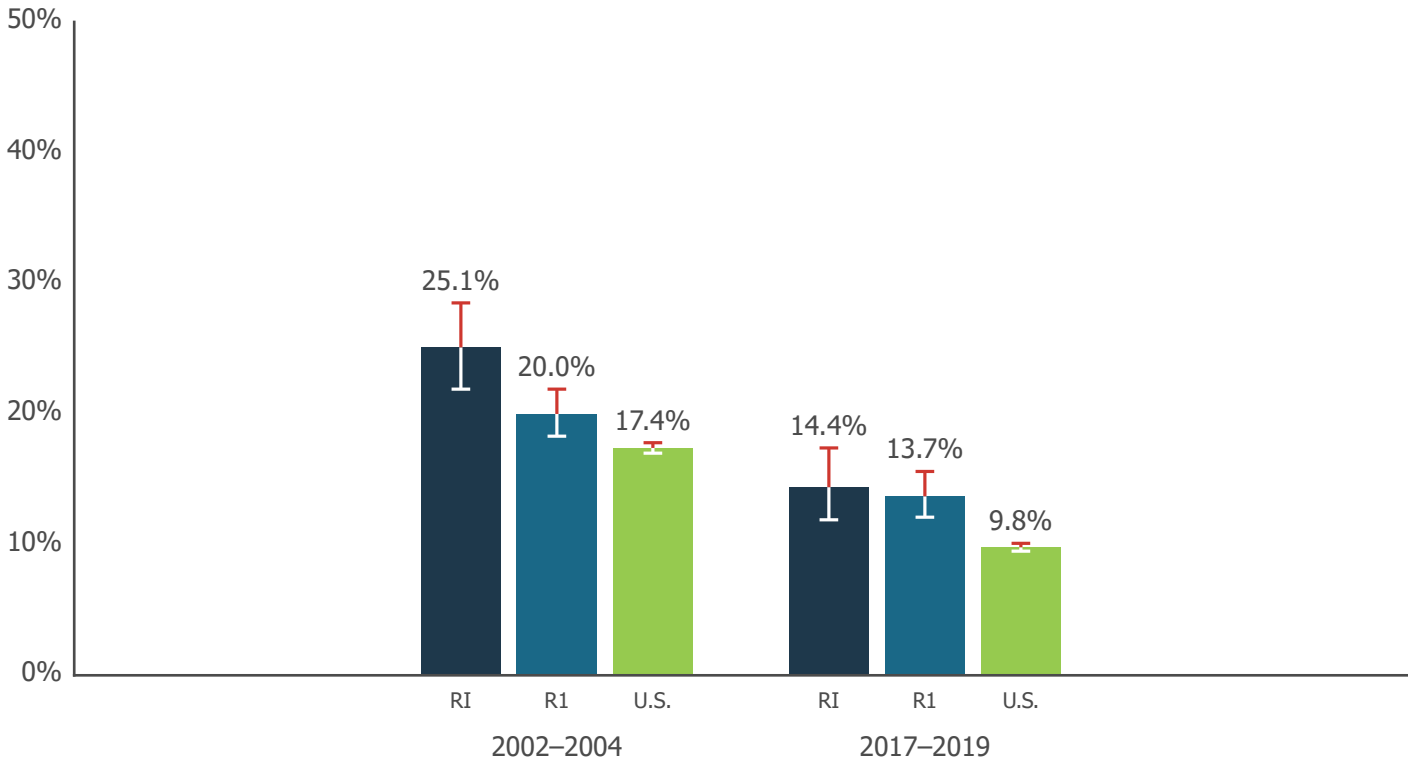
Alcohol Use Disorder

Changes in Past-Year Alcohol Use Disorder among Young Adults Aged 18–25 in Rhode Island, Region 1, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]



Among young adults aged 18–25 in Rhode Island, the annual average percentage of alcohol use disorder in the past year decreased between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year alcohol use disorder in Rhode Island was **14.4%** (or **18,000**), similar to the regional average (**13.7%**) but higher than the national average (**9.8%**).



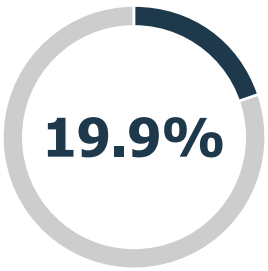
Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Young Adult Substance Use and Use Disorders

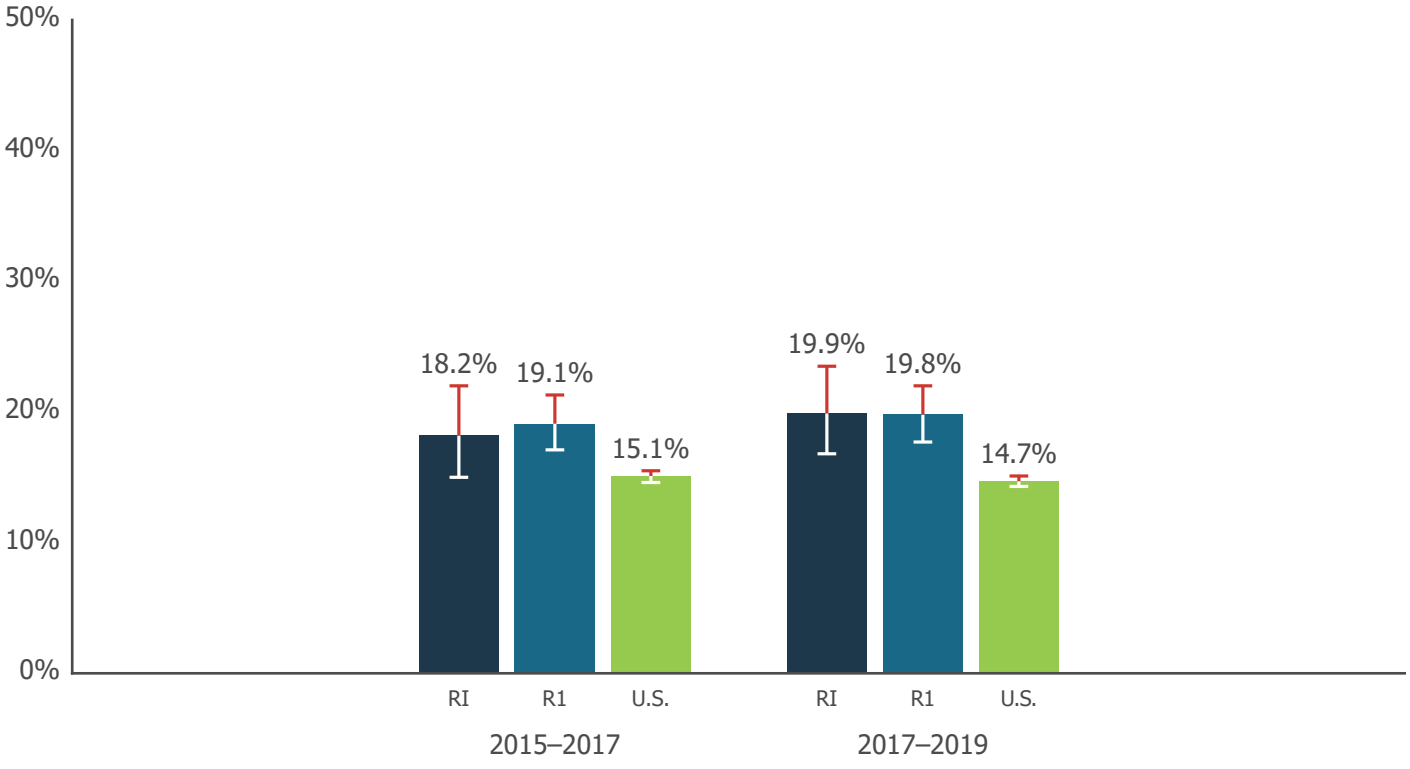
Substance Use Disorder

Changes in Past-Year Substance Use Disorder among Young Adults Aged 18–25 in Rhode Island, Region 1, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1]



Among young adults aged 18–25 in Rhode Island, the annual average percentage of substance use disorder in the past year did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year substance use disorder in Rhode Island was **19.9%** (or **25,000**), similar to the regional average (**19.8%**) but higher than the national average (**14.7%**).



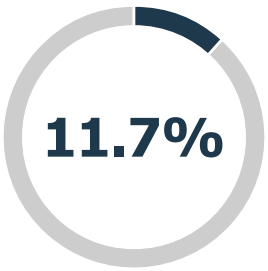
Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

Young Adult Mental Health

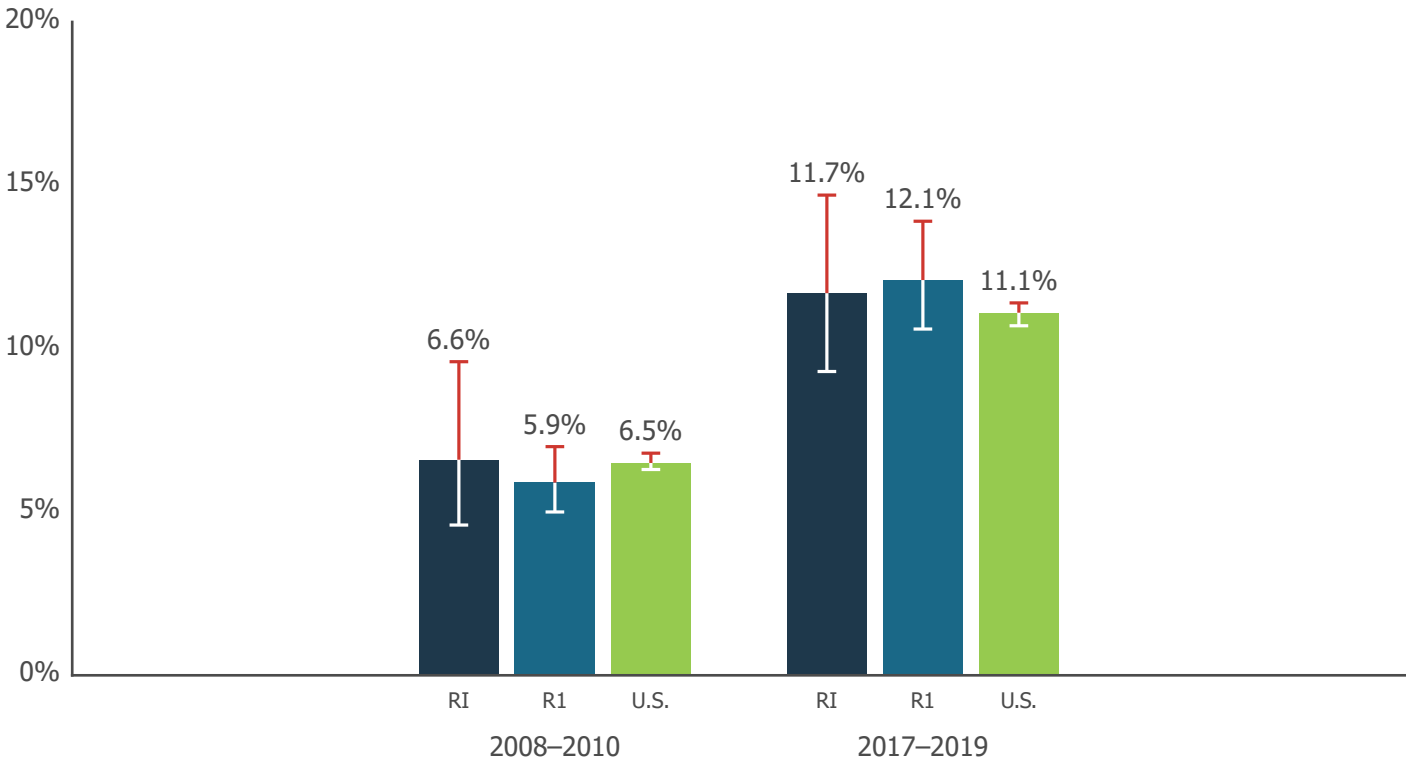
Serious Thoughts of Suicide

Changes in Past-Year Serious Thoughts of Suicide among Young Adults Aged 18–25 in Rhode Island, Region 1, and the United States (Annual Averages, 2008–2010 and 2017–2019)[1,5]



Among young adults aged 18–25 in Rhode Island, the annual average percentage with serious thoughts of suicide in the past year increased between 2008–2010 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year serious thoughts of suicide in Rhode Island was **11.7%** (or **15,000**), similar to both the regional average (**12.1%**) and the national average (**11.1%**).



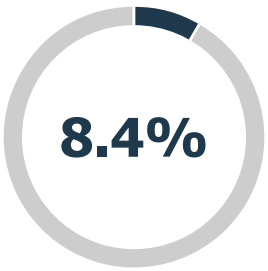
Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008–2010 and 2017–2019.

Young Adult Mental Health

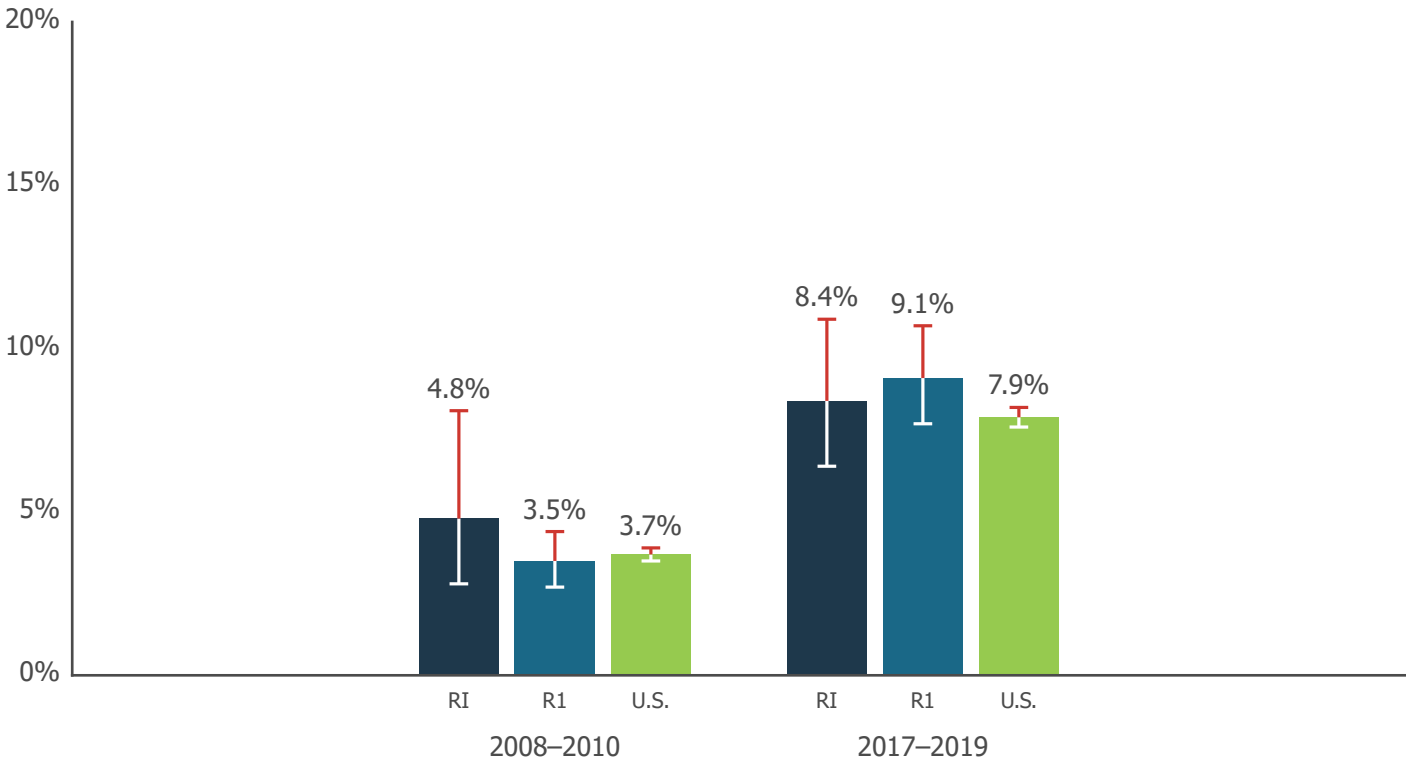
Serious Mental Illness

Changes in Past-Year Serious Mental Illness (SMI) among Young Adults Aged 18–25 in Rhode Island, Region 1, and the United States (Annual Averages, 2008–2010 and 2017–2019)[1,6]



Among young adults aged 18–25 in Rhode Island, the annual average percentage with SMI in the past year increased between 2008–2010 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year SMI in Rhode Island was **8.4%** (or **10,000**), similar to both the regional average (**9.1%**) and the national average (**7.9%**).



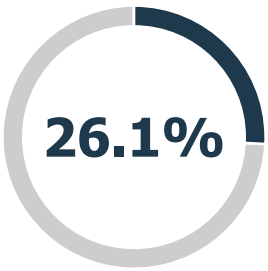
Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008–2010 and 2017–2019.

Substance Use, Misuse, and Use Disorders

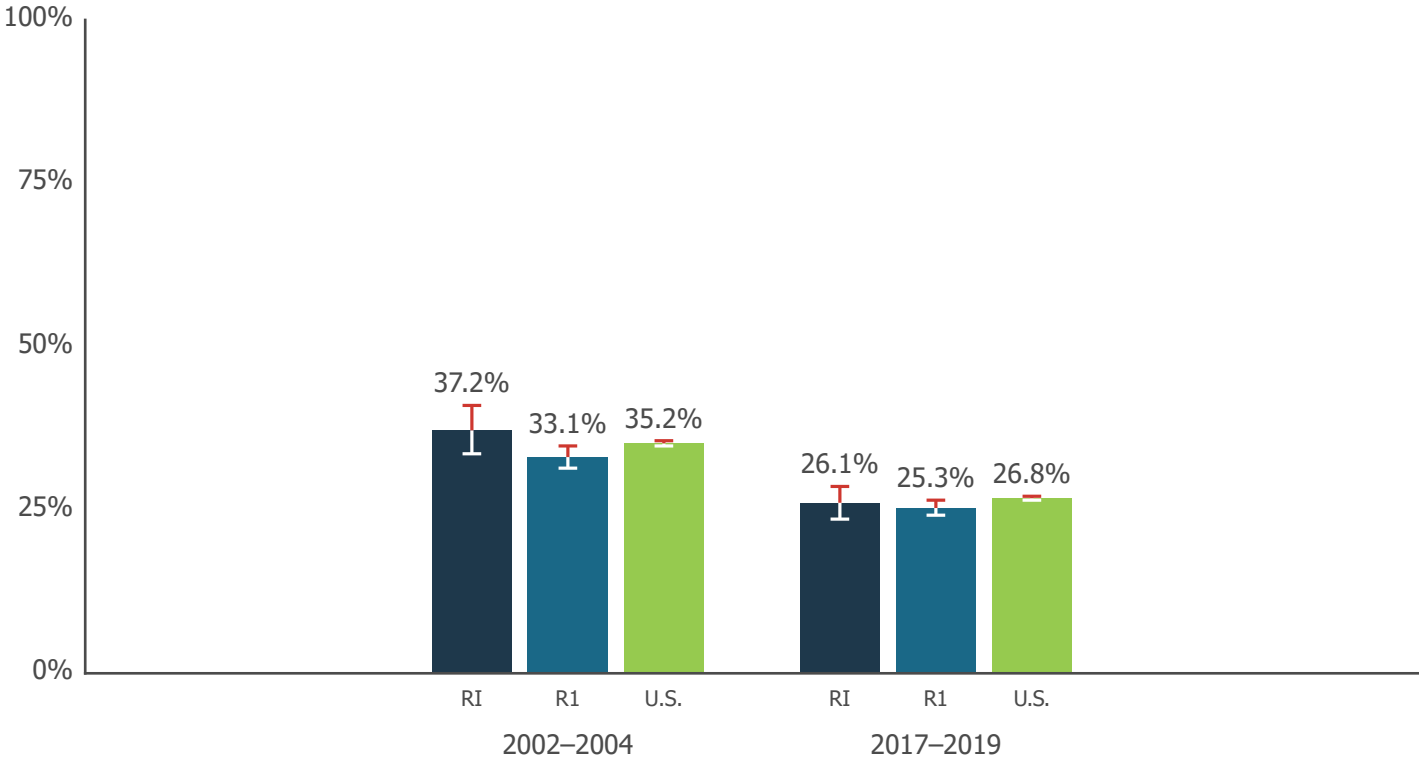
Tobacco Use

Changes in Past-Year Tobacco Use among People Aged 12 or Older in Rhode Island, Region 1, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]



Among people aged 12 or older in Rhode Island, the annual average percentage of tobacco use in the past year decreased between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year tobacco use in Rhode Island was **26.1%** (or **237,000**), similar to both the regional average (**25.3%**) and the national average (**26.8%**).



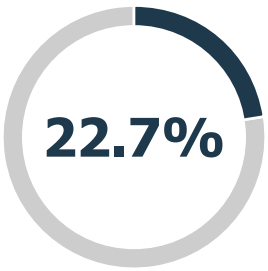
Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Substance Use, Misuse, and Use Disorders

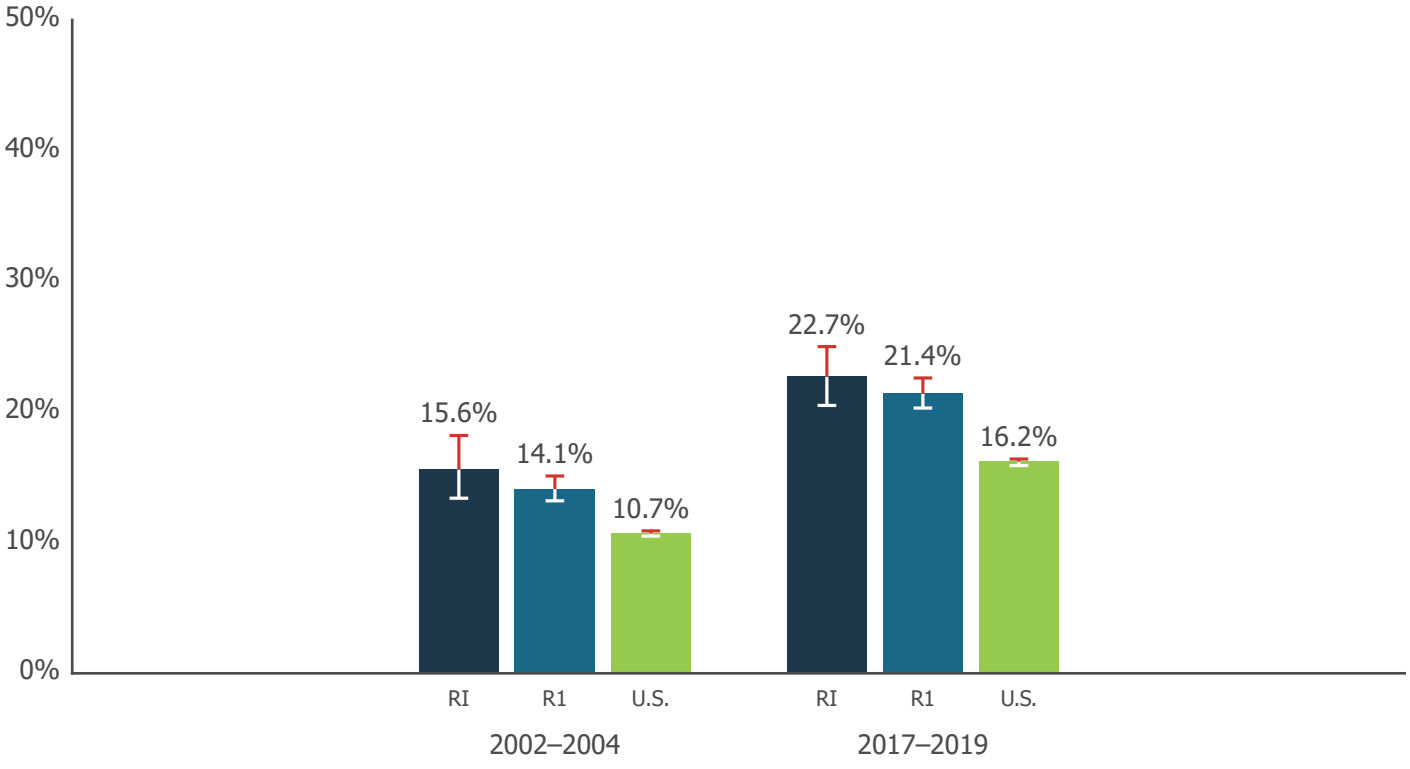
Marijuana Use

Changes in Past-Year Marijuana Use among People Aged 12 or Older in Rhode Island, Region 1, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]



Among people aged 12 or older in Rhode Island, the annual average percentage of marijuana use in the past year increased between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year marijuana use in Rhode Island was **22.7%** (or **207,000**), similar to the regional average (**21.4%**) but higher than the national average (**16.2%**).



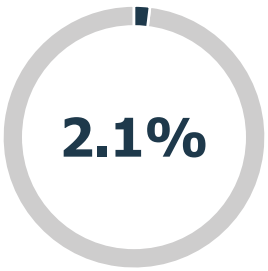
Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Substance Use, Misuse, and Use Disorders

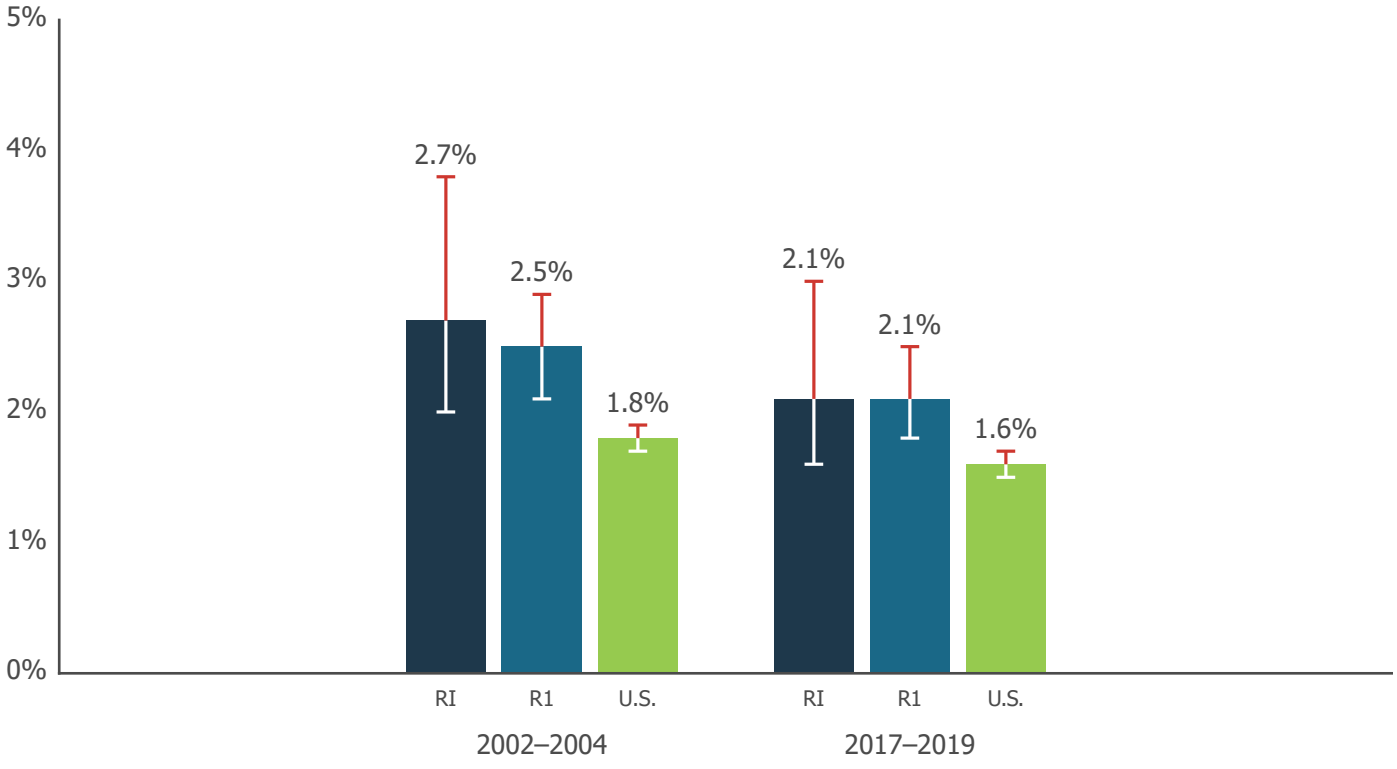
Marijuana Use Disorder

Changes in Past-Year Marijuana Use Disorder among People Aged 12 or Older in Rhode Island, Region 1, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]



Among people aged 12 or older in Rhode Island, the annual average percentage of marijuana use disorder in the past year did not significantly change between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year marijuana use disorder in Rhode Island was **2.1%** (or **20,000**), similar to both the regional average (**2.1%**) and the national average (**1.6%**).



Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

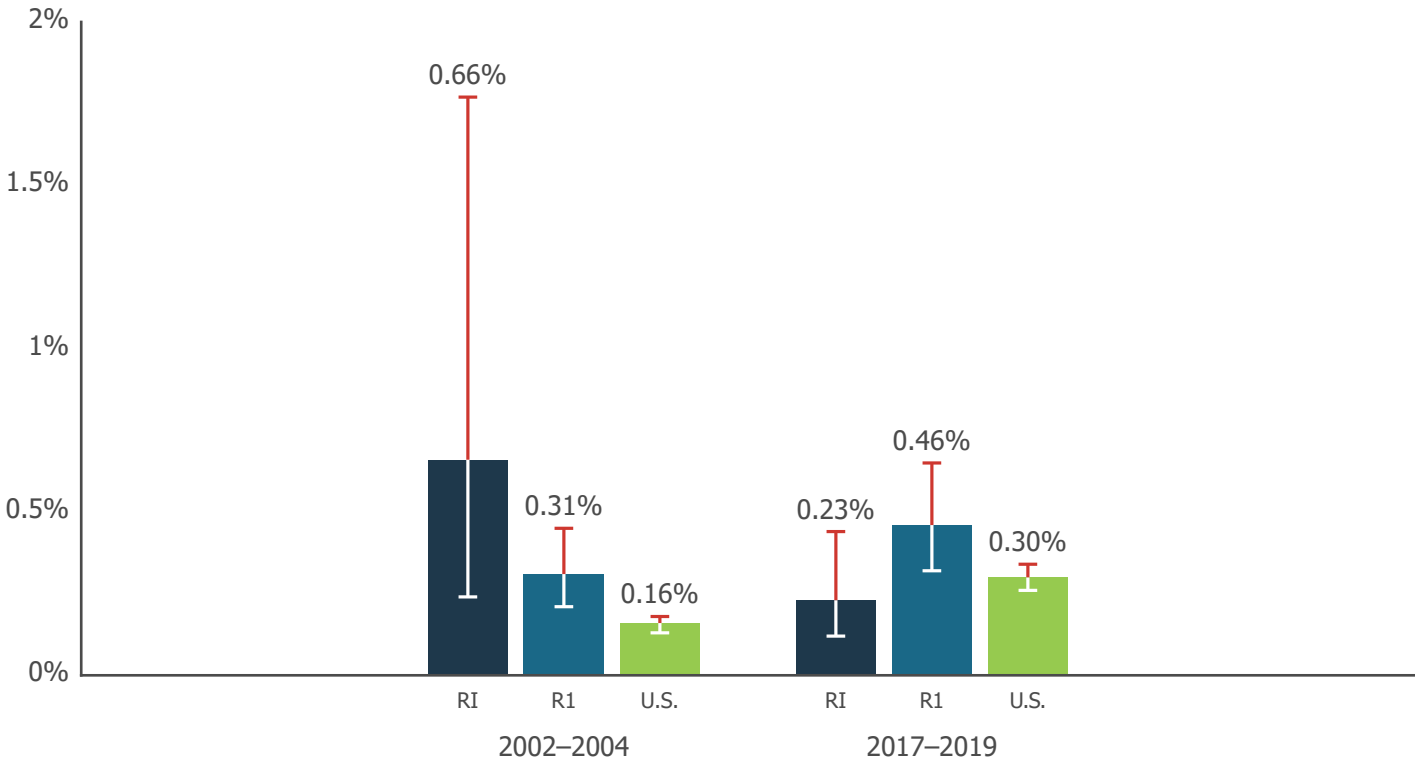
Substance Use, Misuse, and Use Disorders

Heroin Use

Changes in Past-Year Heroin Use among People Aged 12 or Older in Rhode Island, Region 1, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]

Among people aged 12 or older in Rhode Island, the annual average percentage of heroin use in the past year did not significantly change between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year heroin use in Rhode Island was **0.23%** (or **2,000**), lower than the regional average (**0.46%**) but similar to the national average (**0.30%**).



Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

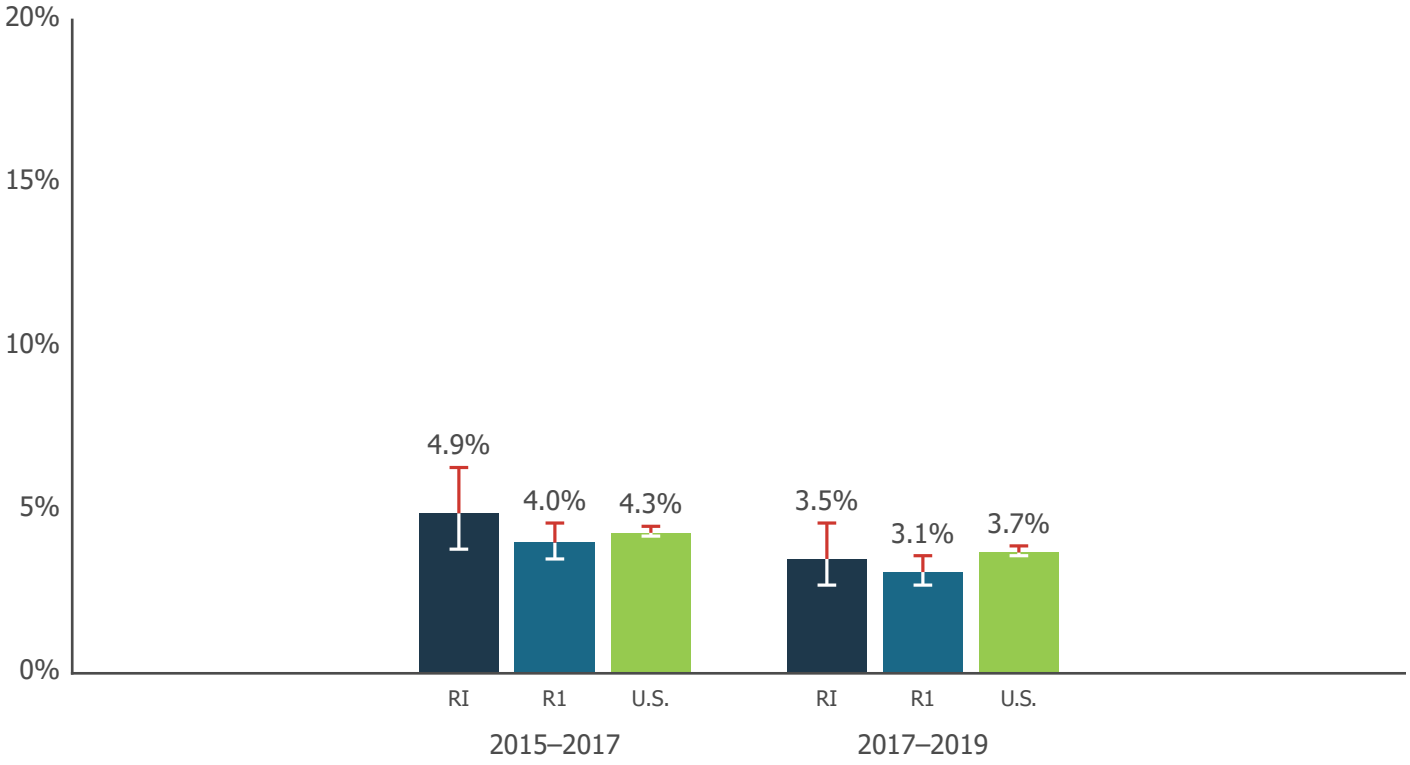
Substance Use, Misuse, and Use Disorders

Misuse of Prescription Pain Relievers

Changes in Past-Year Misuse of Prescription Pain Relievers among People Aged 12 or Older in Rhode Island, Region 1, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1]

Among people aged 12 or older in Rhode Island, the annual average percentage of prescription pain reliever misuse in the past year did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year prescription pain reliever misuse in Rhode Island was **3.5%** (or **32,000**), similar to both the regional average (**3.1%**) and the national average (**3.7%**).



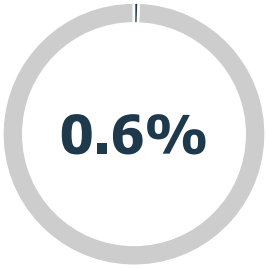
Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

Substance Use, Misuse, and Use Disorders

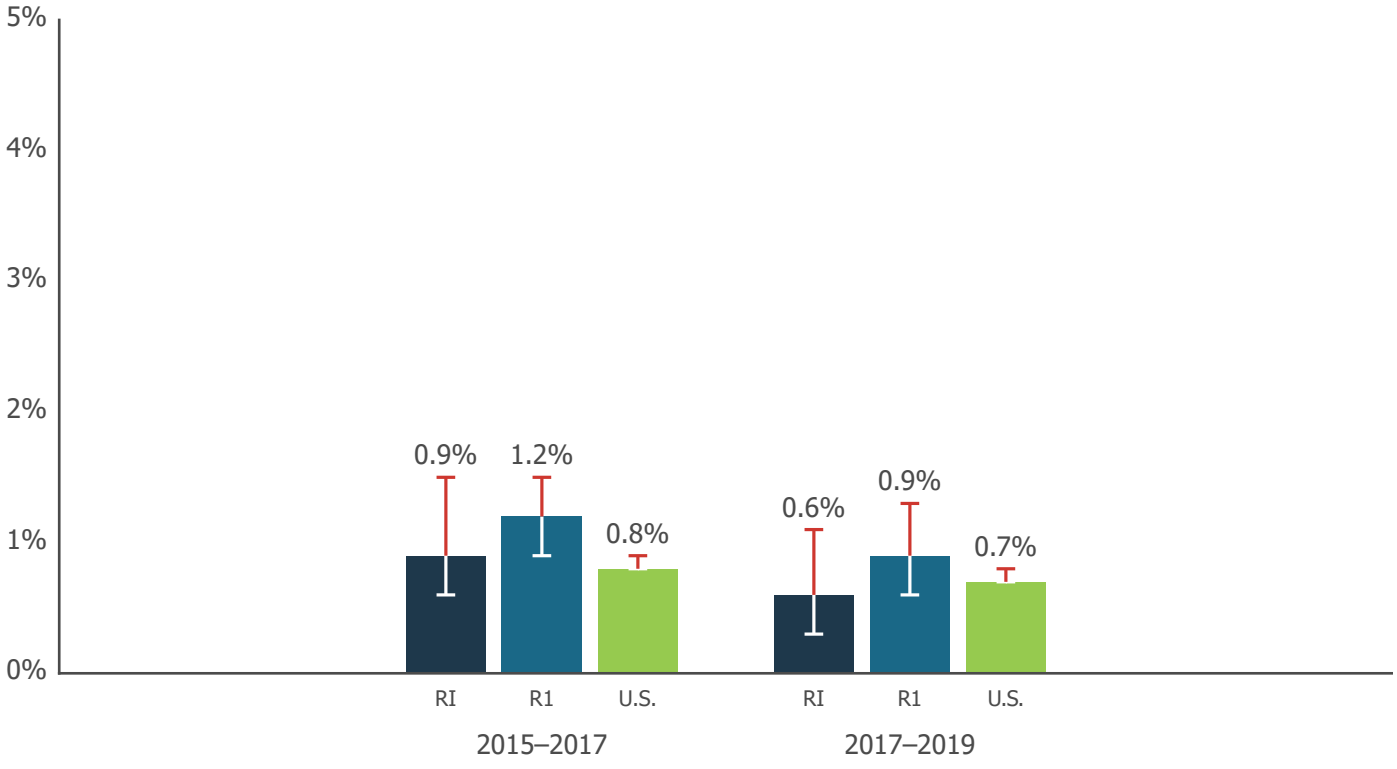
Opioid Use Disorder

Changes in Past-Year Opioid Use Disorder among People Aged 12 or Older in Rhode Island, Region 1, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1]



Among people aged 12 or older in Rhode Island, the annual average percentage of opioid use disorder in the past year did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year opioid use disorder in Rhode Island was **0.6%** (or **5,000**), similar to both the regional average (**0.9%**) and the national average (**0.7%**).



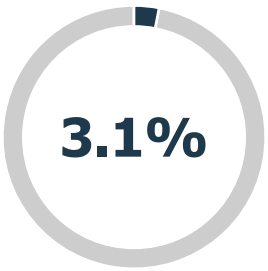
Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

Substance Use, Misuse, and Use Disorders

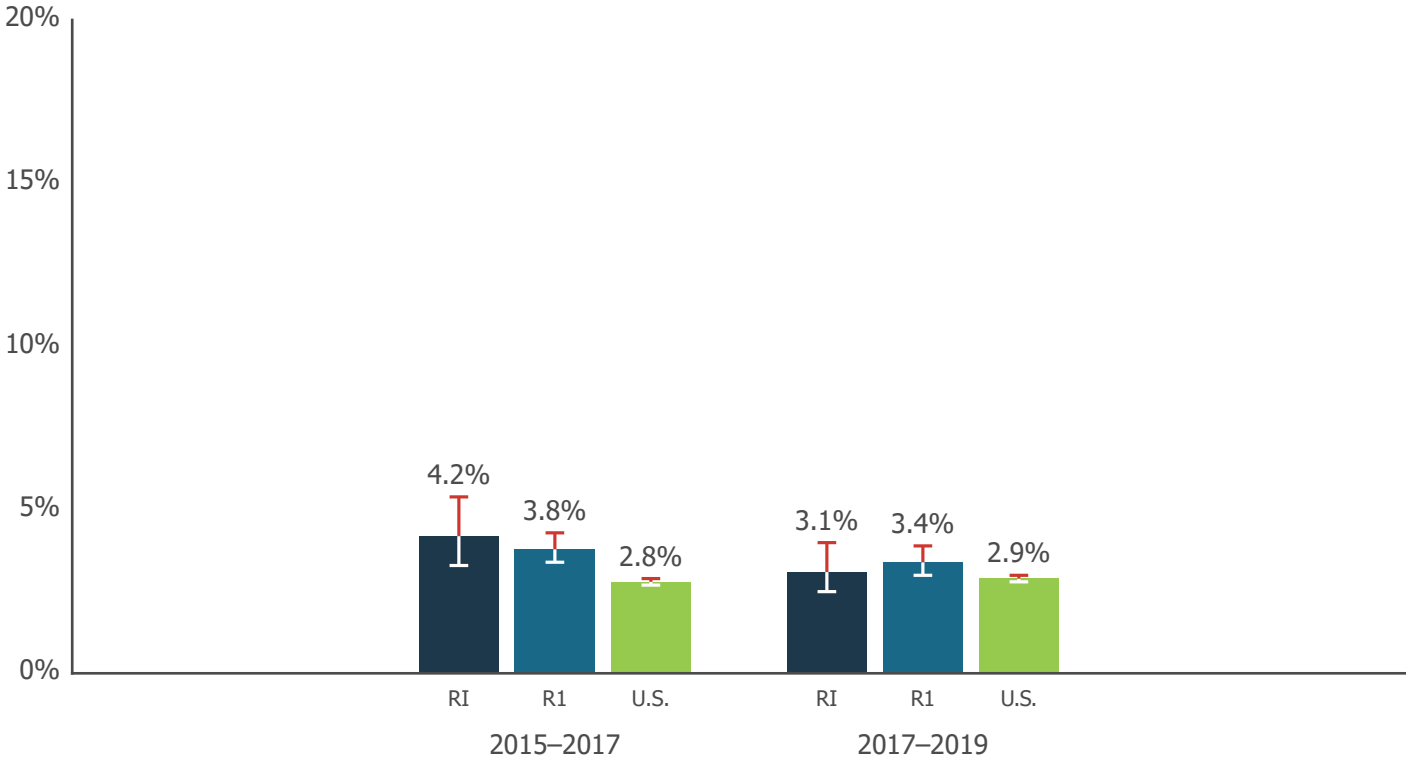
Illicit Drug Use Disorder

Changes in Past-Year Illicit Drug Use Disorder among People Aged 12 or Older in Rhode Island, Region 1, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1]



Among people aged 12 or older in Rhode Island, the annual average percentage of illicit drug use disorder in the past year decreased between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year illicit drug use disorder in Rhode Island was **3.1%** (or **29,000**), similar to both the regional average (**3.4%**) and the national average (**2.9%**).



Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

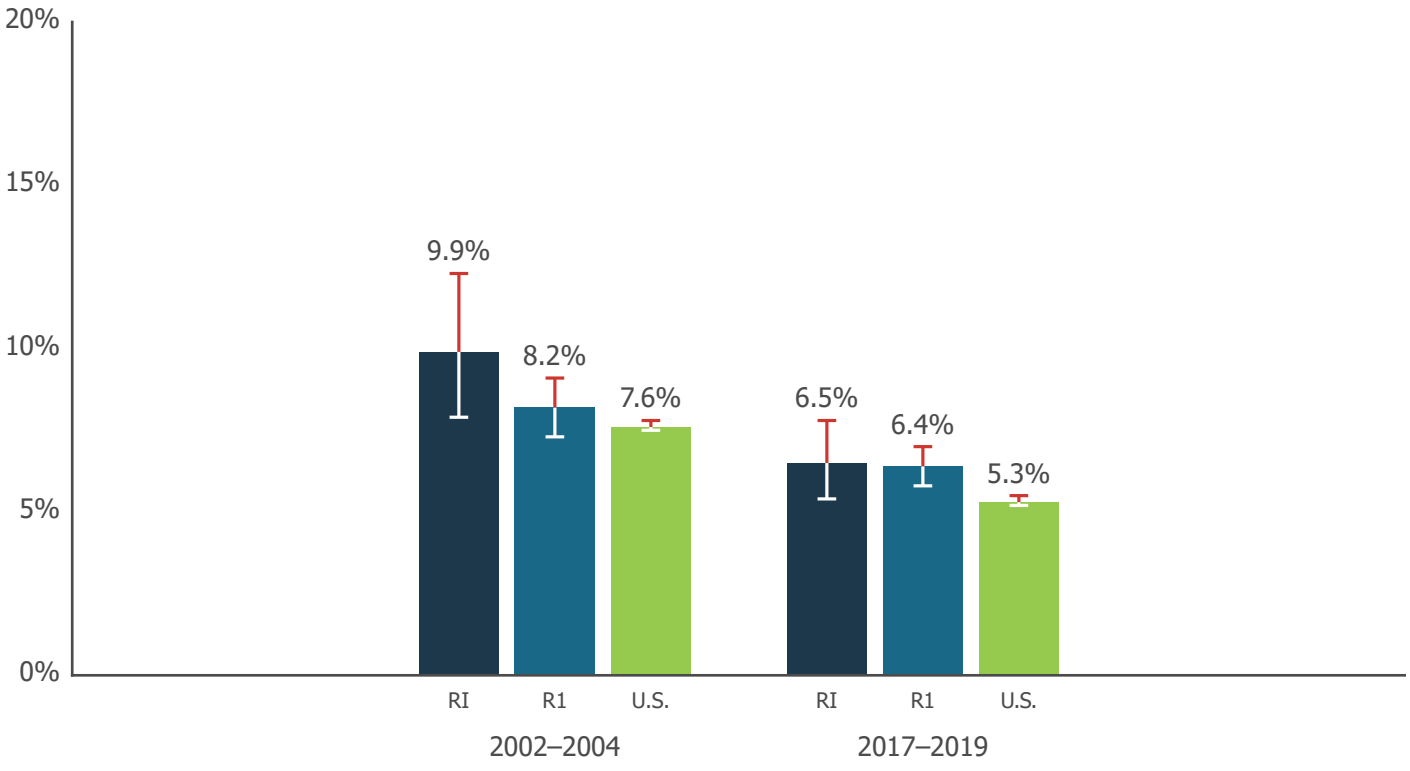
Substance Use, Misuse, and Use Disorders

Alcohol Use Disorder

Changes in Past-Year Alcohol Use Disorder among People Aged 12 or Older in Rhode Island, Region 1, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]

Among people aged 12 or older in Rhode Island, the annual average percentage of alcohol use disorder in the past year decreased between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year alcohol use disorder in Rhode Island was **6.5%** (or **59,000**), similar to both the regional average (**6.4%**) and the national average (**5.3%**).



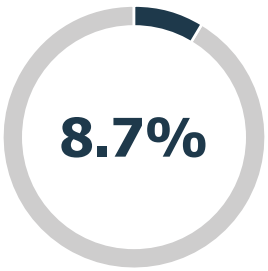
Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Substance Use, Misuse, and Use Disorders

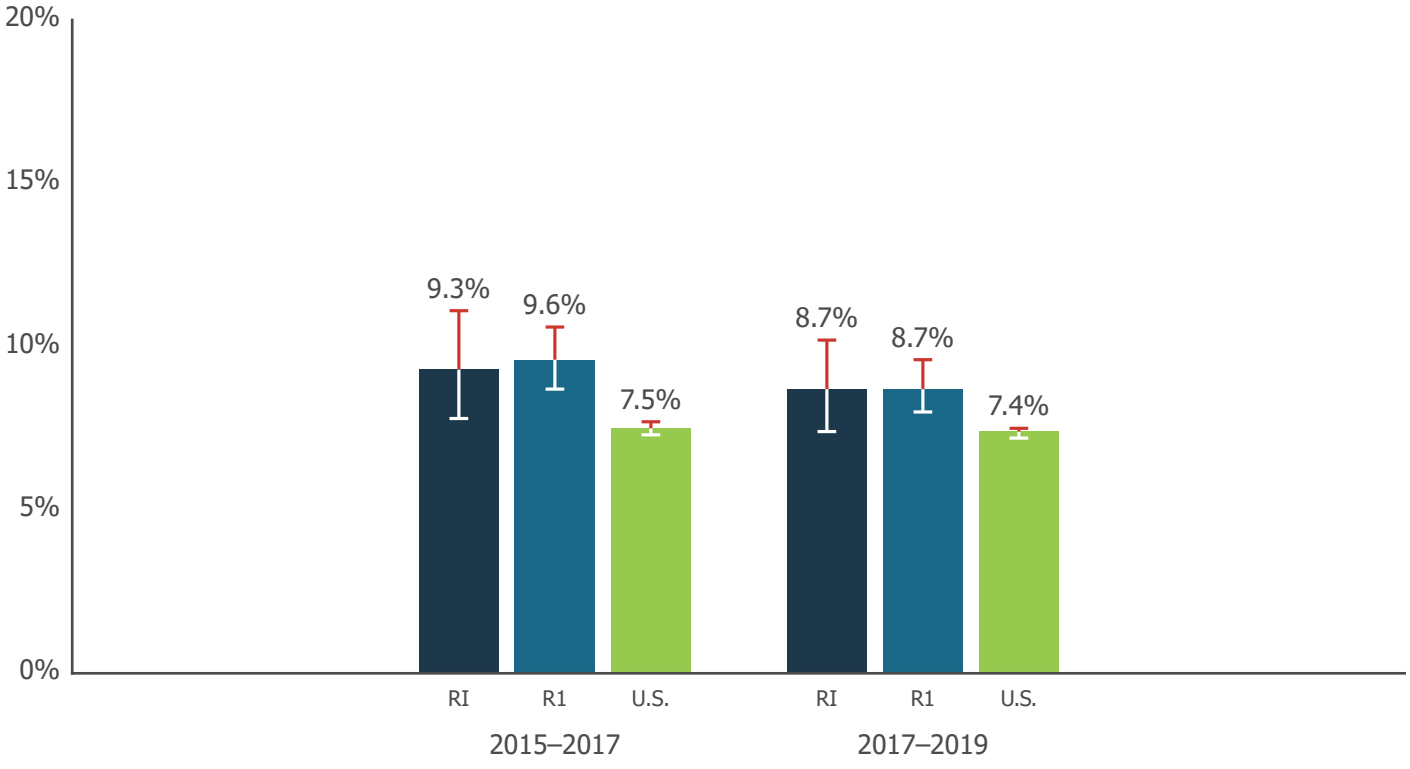
Substance Use Disorder

Changes in Past-Year Substance Use Disorder among People Aged 12 or Older in Rhode Island, Region 1, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1]



Among people aged 12 or older in Rhode Island, the annual average percentage of substance use disorder in the past year did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year substance use disorder in Rhode Island was **8.7%** (or **79,000**), similar to both the regional average (**8.7%**) and the national average (**7.4%**).



Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

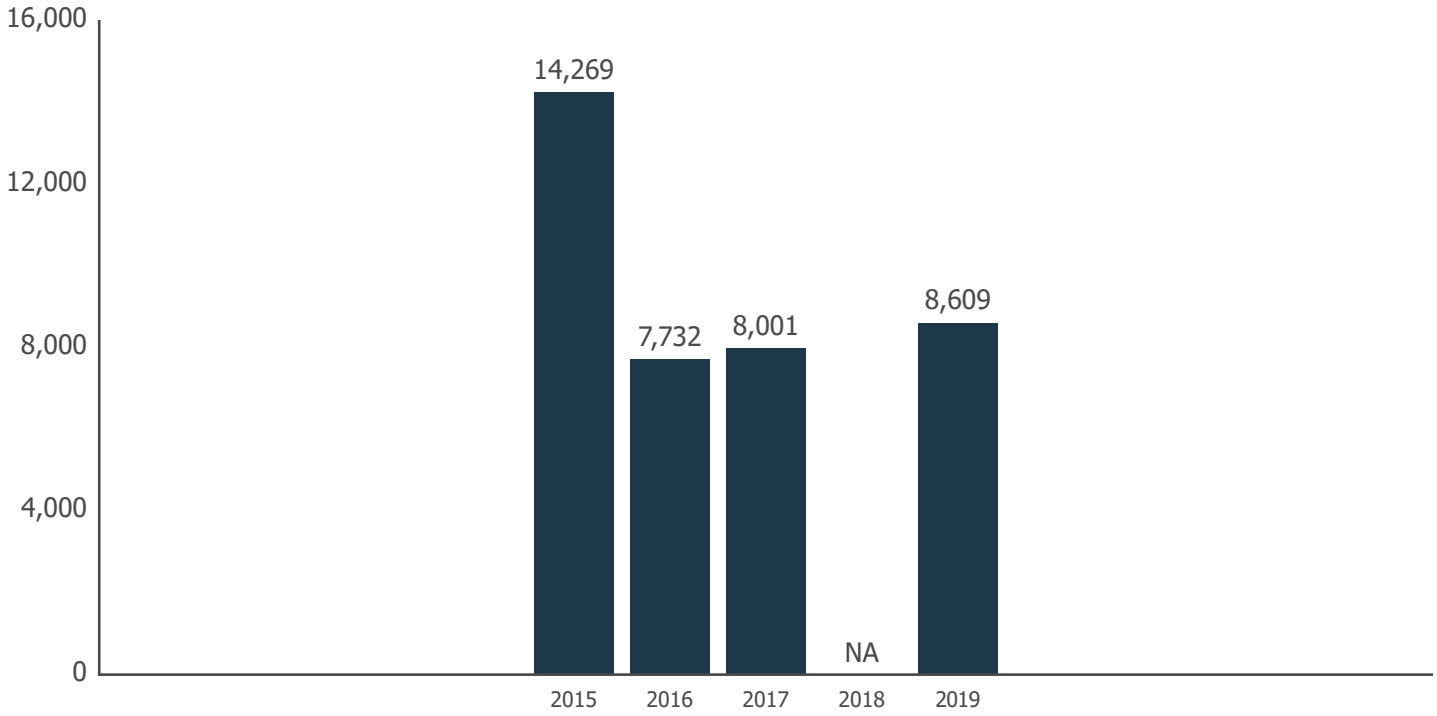
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

Substance Use Treatment

Enrollment and Treatment Focus

Changes in the Number of People Enrolled in Substance Use Treatment in Rhode Island (Single-Day Counts, 2015–2017 and 2019)[7,8]

In a single-day count in March 2019, **8,609** people in Rhode Island were enrolled in substance use treatment—a decrease from **14,269** people in 2015.



NA = Not Available.

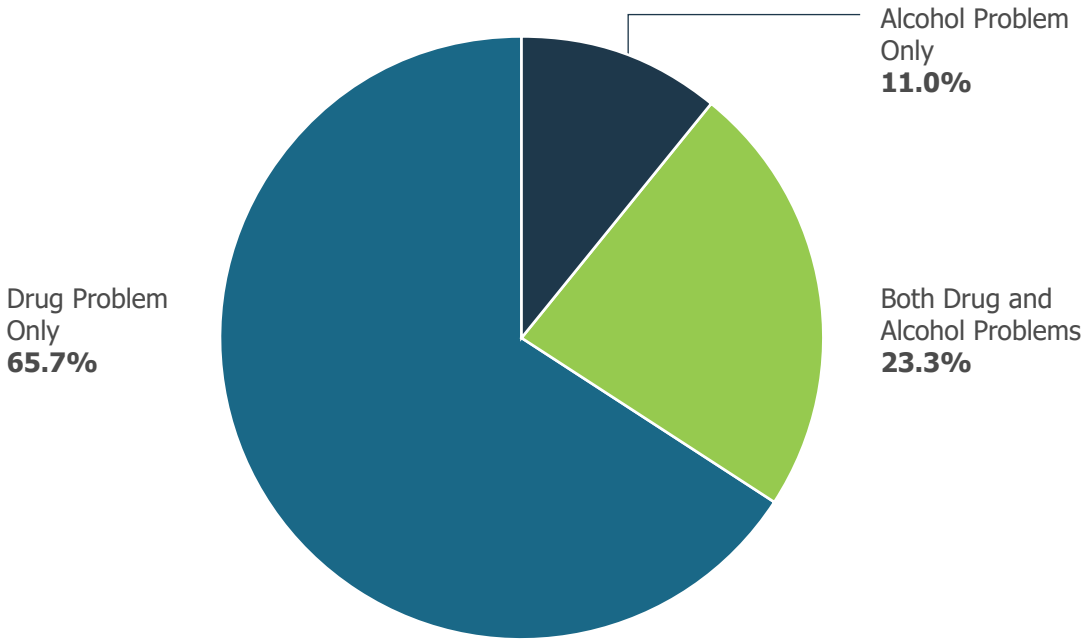
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2015–2017 and 2019.

Substance Use Treatment

Enrollment and Treatment Focus

Substance Use Problems among People Enrolled in Substance Use Treatment in Rhode Island (Single-Day Count, 2019)[7,8,9]

Among people in Rhode Island enrolled in substance use treatment in a single-day count in March 2019, **65.7%** received treatment for a drug problem only, **11.0%** received treatment for an alcohol problem only, and **23.3%** received treatment for both drug and alcohol problems.



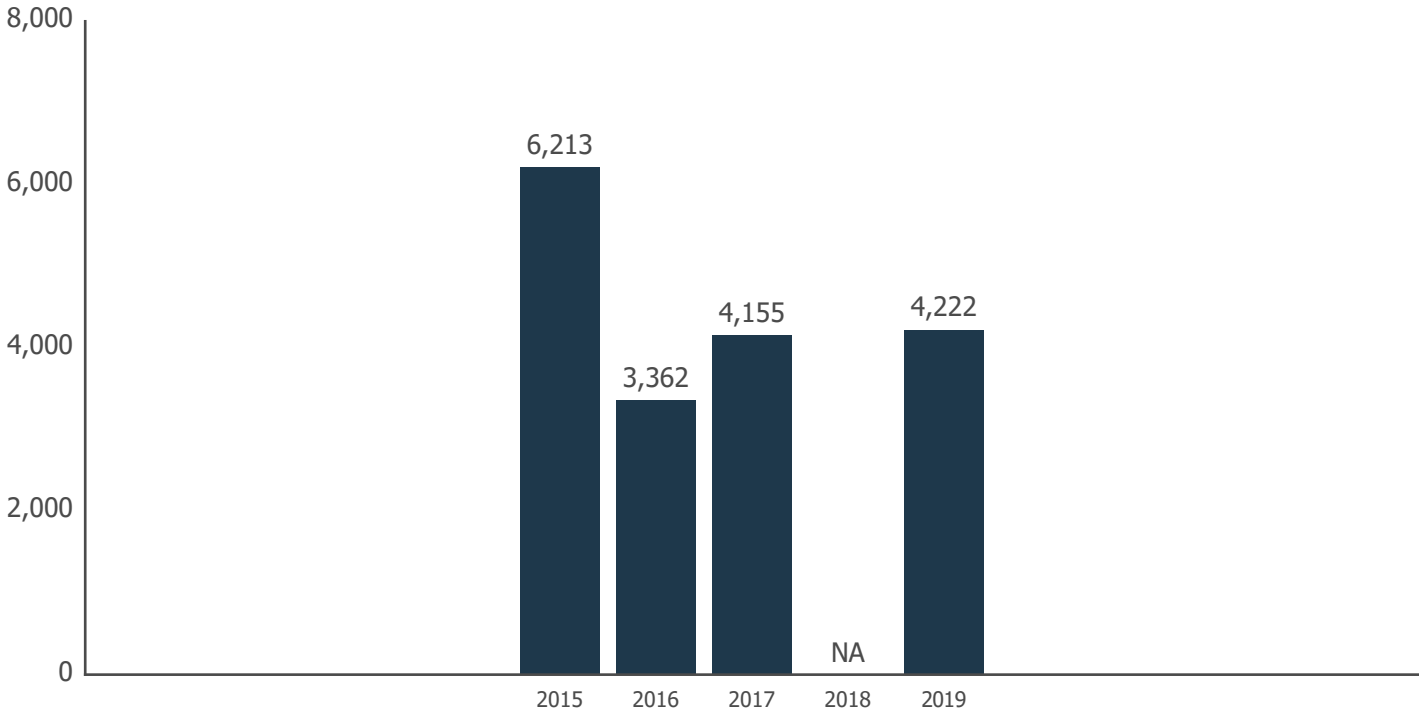
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2019.

Substance Use Treatment

Opioids (Medication-Assisted Therapy [MAT])

Changes in the Number of People Enrolled in Opioid Treatment Programs in Rhode Island Receiving Methadone (Single-Day Counts, 2015–2017 and 2019)[7,8,10]

In a single-day count in March 2019, **4,222** people in Rhode Island were receiving methadone in opioid treatment programs as part of their substance use treatment—a decrease from **6,213** people in 2015.



NA = Not Available.

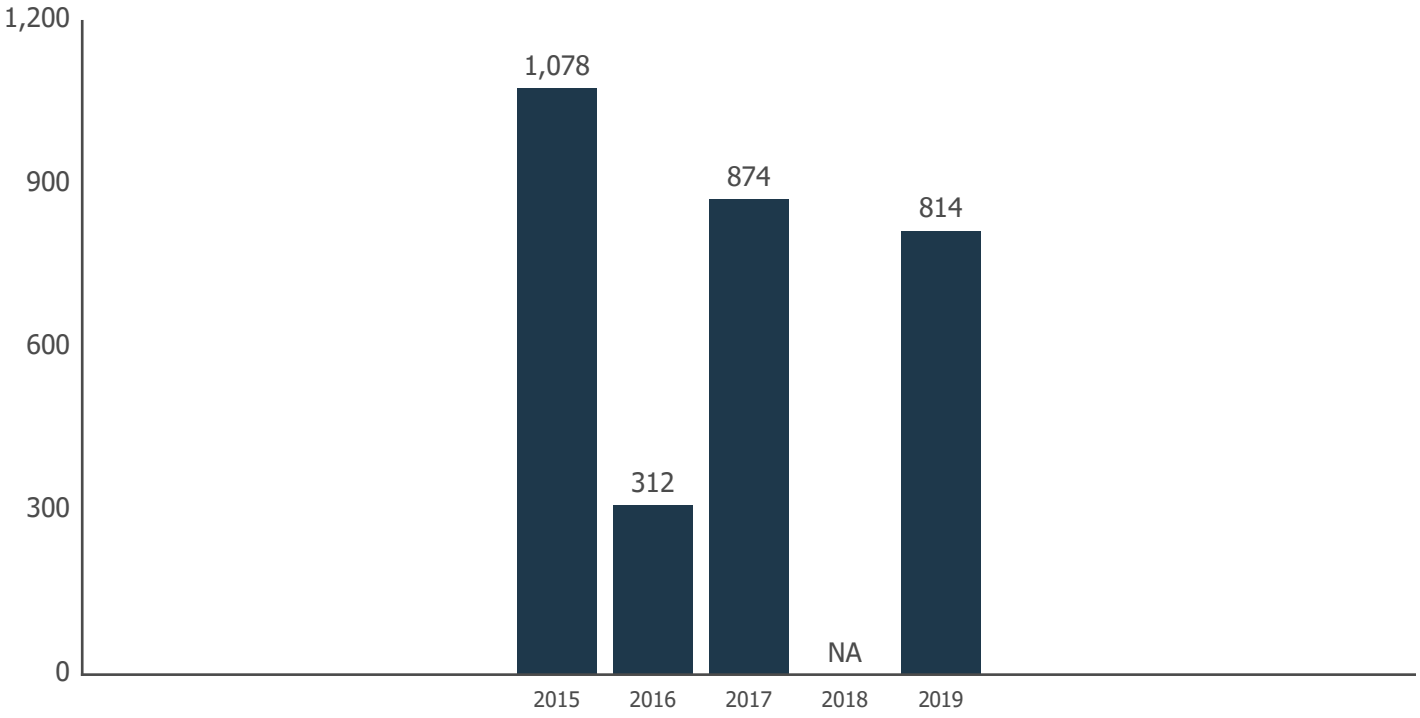
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2015–2017 and 2019.

Substance Use Treatment

Opioids (Medication-Assisted Therapy [MAT])

Changes in the Number of People Enrolled in Substance Use Treatment in Rhode Island Receiving Buprenorphine (Single-Day Counts, 2015–2017 and 2019)[7,8,10,11]

In a single-day count in March 2019, **814** people in Rhode Island were receiving buprenorphine as part of their substance use treatment—a decrease from **1,078** people in 2015.



NA = Not Available.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2015–2017 and 2019.

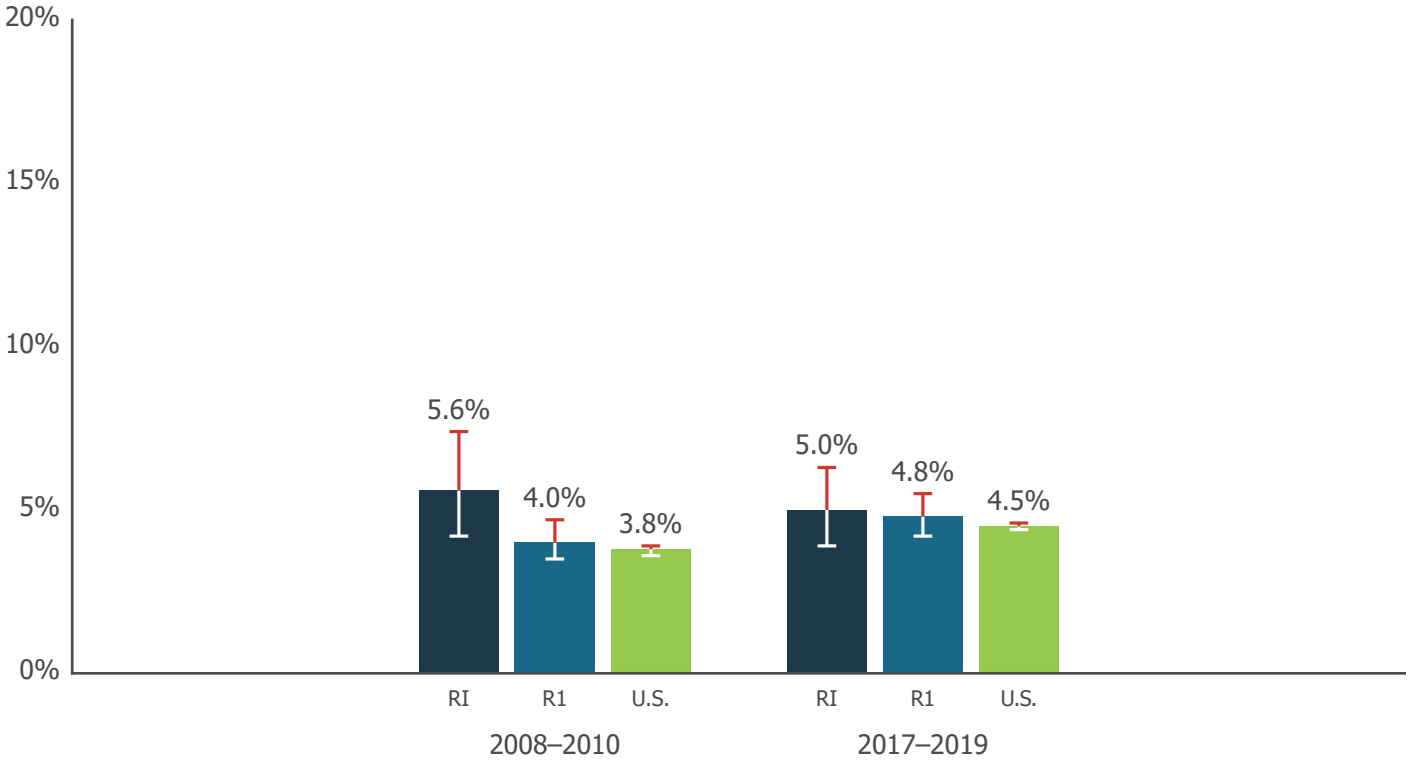
Adult Mental Health and Service Use

Serious Thoughts of Suicide

Changes in Past-Year Serious Thoughts of Suicide among Adults Aged 18 or Older in Rhode Island, Region 1, and the United States (Annual Averages, 2008–2010 and 2017–2019)[1,5]

Among adults aged 18 or older in Rhode Island, the annual average percentage with serious thoughts of suicide in the past year did not significantly change between 2008–2010 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year serious thoughts of suicide in Rhode Island was **5.0%** (or **41,000**), similar to both the regional average (**4.8%**) and the national average (**4.5%**).



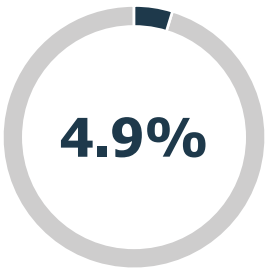
Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008–2010 and 2017–2019.

Adult Mental Health and Service Use

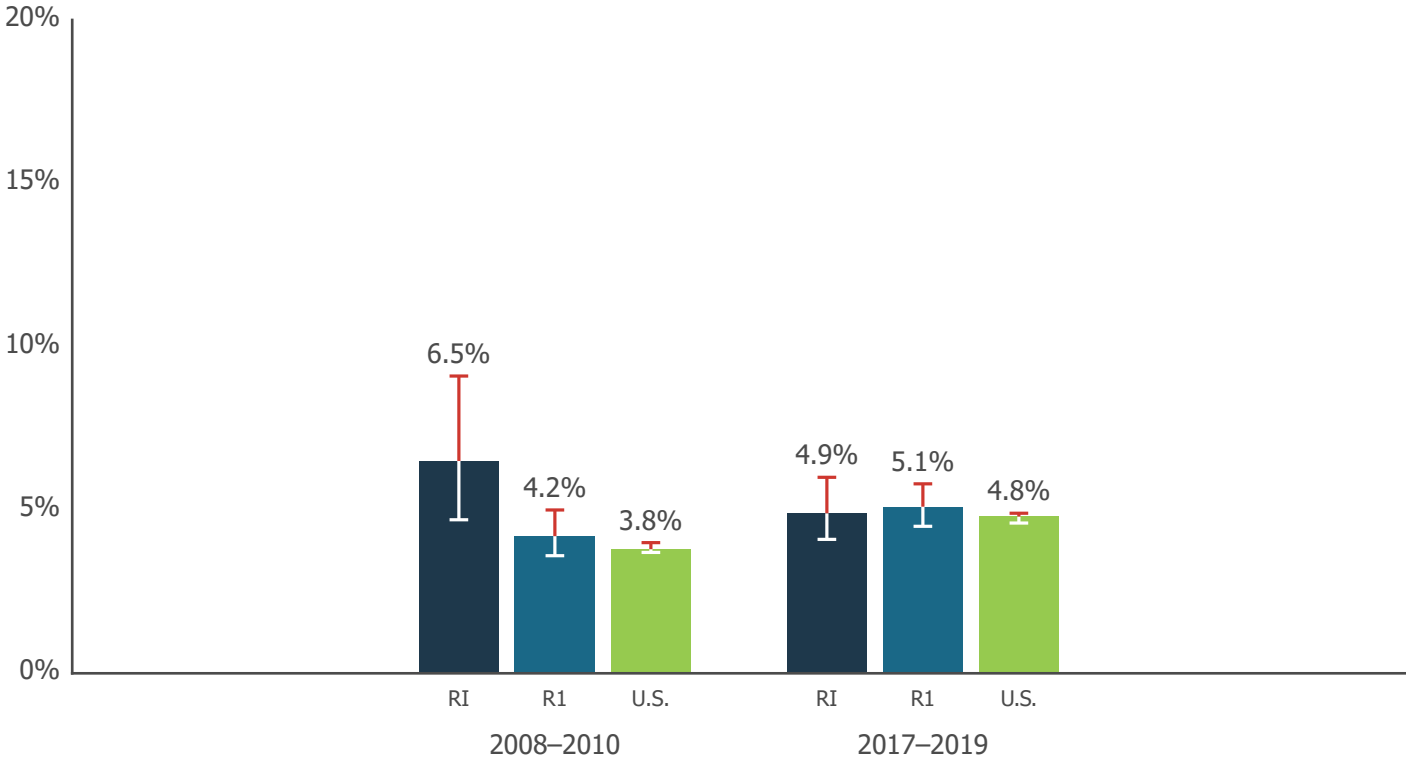
Serious Mental Illness

Changes in Past-Year Serious Mental Illness (SMI) among Adults Aged 18 or Older in Rhode Island, Region 1, and the United States (Annual Averages, 2008–2010 and 2017–2019)[1,6]



Among adults aged 18 or older in Rhode Island, the annual average percentage with SMI in the past year did not significantly change between 2008–2010 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year SMI in Rhode Island was **4.9%** (or **41,000**), similar to both the regional average (**5.1%**) and the national average (**4.8%**).



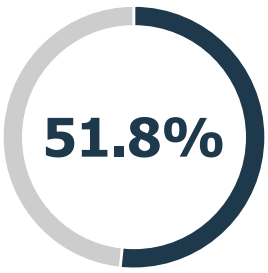
Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008–2010 and 2017–2019.

Adult Mental Health and Service Use

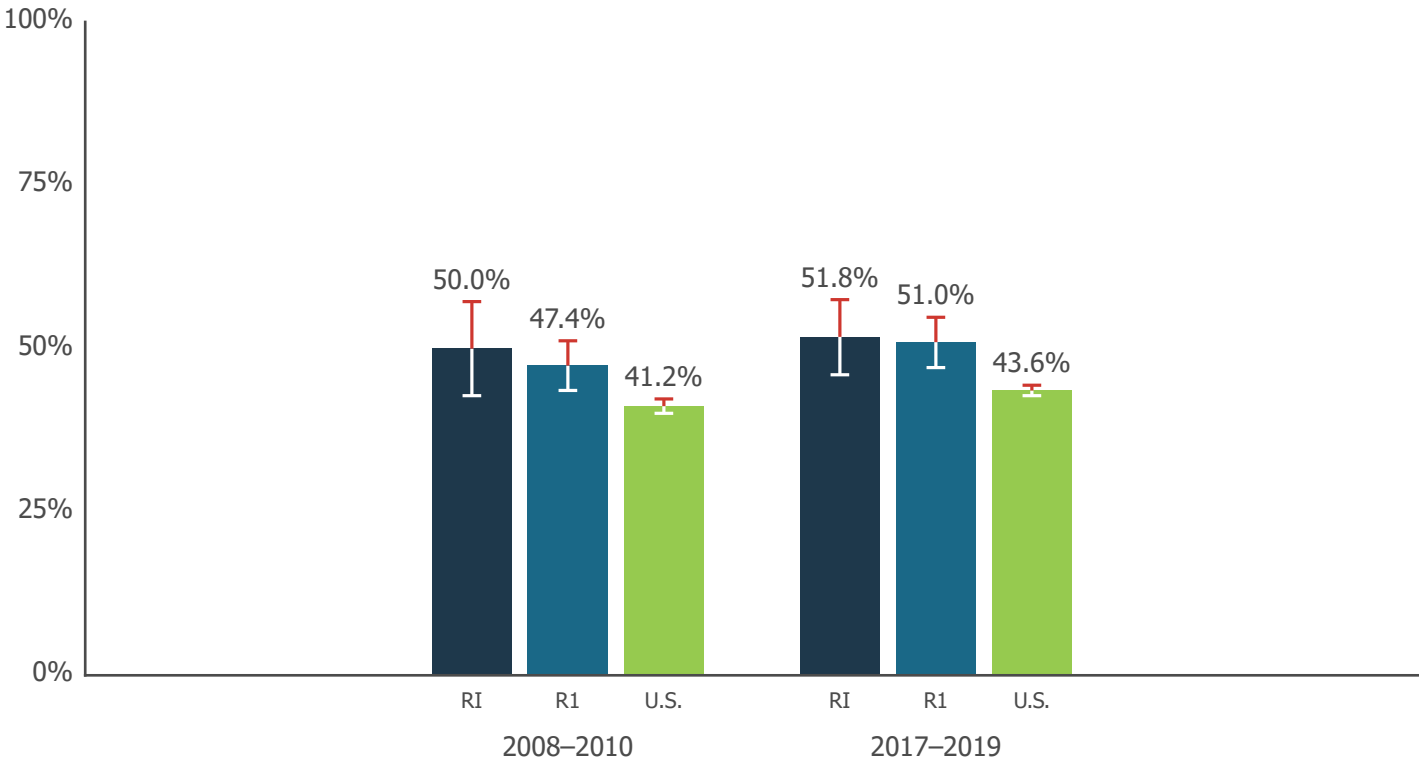
Mental Health Service Use among Adults with Any Mental Illness

Changes in Past-Year Mental Health Service Use among Adults Aged 18 or Older with Any Mental Illness (AMI) in Rhode Island, Region 1, and the United States (Annual Averages, 2008–2010 and 2017–2019)[1,6,12]



Among adults aged 18 or older in Rhode Island, the annual average percentage with AMI who received mental health services in the past year did not significantly change between 2008–2010 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year mental health service use among those with AMI in Rhode Island was **51.8%** (or **97,000**), similar to the regional average (**51.0%**) but higher than the national average (**43.6%**).



Error bars indicate 95% confidence interval of the estimate.
RI = Rhode Island; R1 = Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008–2010 and 2017–2019.

Figure Notes

1 Estimates are annual averages based on combined 2017–2019 NSDUH data or NSDUH data for other combined years as indicated.

2 Respondents with unknown past-year major depressive episode (MDE) data were excluded.

3 Respondents with unknown past-year MDE or unknown treatment data were excluded.

4 Consistent with federal definitions and other federal data collections, the NSDUH definition for binge alcohol use since 2015 differs for males and females. Thus, this indicator is based only on the 2015–2019 NSDUH data. Binge drinking for males is defined as drinking five or more drinks on the same occasion on at least 1 day in the past 30 days, which is unchanged from the threshold prior to 2015. Since 2015, binge alcohol use for females has been defined as drinking four or more drinks on the same occasion on at least 1 day in the past 30 days.

5 Estimates were based only on responses to suicidality items in the NSDUH Mental Health module. Respondents with unknown suicidality information were excluded.

6 For further information, see *The NSDUH Report: Revised Estimates of Mental Illness from the National Survey on Drug Use and Health*, which is available on the SAMHSA website at https://www.samhsa.gov/data/sites/default/files/NSDUH148/NSDUH148/sr148-mental-illness-estimates.pdf.

7 Significance testing was not conducted on these data. Conducting statistical significance tests is not necessary because these are counts of people enrolled at all treatment facilities (rather than estimates from a sample of treatment facilities).

8 Single-day counts reflect the number of individuals who were enrolled in substance use treatment on the last business day in March: March 31, 2015; March 31, 2016; March 31, 2017; and March 29, 2019. Single-day counts of the number of individuals enrolled in substance use treatment were not included in the 2018 National Survey of Substance Abuse Treatment Services (N–SSATS).

9 Enrollees whose substances were unknown were excluded.

10 These counts reflect only individuals who were receiving these specific medication-assisted therapies (MATs) as part of their opioid treatment in specialty substance abuse treatment programs; they do not include counts of individuals who were receiving other types of treatment (such as those who received MAT from private physicians) for their opioid addiction on the reference dates.

Figure Notes

11 Physicians who obtain specialized training per the Drug Addiction Treatment Act of 2000 (DATA 2000) may prescribe buprenorphine to treat opioid addiction. Some physicians are in private, office-based practices; others are affiliated with substance abuse treatment facilities or programs and may prescribe buprenorphine to clients at those facilities. Additionally, opioid treatment programs (OTPs) may also prescribe and/or dispense buprenorphine. The buprenorphine single-day counts include only those clients who received/were prescribed buprenorphine by physicians affiliated with substance abuse treatment facilities; they do not include clients from private practice physicians.

12 Respondents were not to include treatment for drug or alcohol use. Respondents with unknown service use information were excluded. Estimates were based only on responses to items in the NSDUH Adult Mental Health Service Utilization module.

Definitions

Alcohol use disorder and **illicit drug use disorder** are defined using diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV), which include such symptoms as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference with major obligations at work, school, or home during the past year. For details, see American Psychiatric Association (1994).

Any mental illness (AMI) is defined in NSDUH as adults aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet DSM-IV criteria. AMI estimates are based on a predictive model applied to NSDUH data and are not direct measures of diagnostic status. Adults estimated as having a diagnosable mental, behavioral, or emotional disorder in the past year, regardless of their level of functional impairment, were defined as having AMI.

Depression care is defined as seeing or talking to a medical doctor or other professional or using prescription medication for depression in the past year.

Major depressive episode (MDE) is defined as in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), which specifies a period of at least 2 weeks in the past year when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. For details, see American Psychiatric Association (2013).

Marijuana use disorder is defined using diagnostic criteria specified within the DSM-IV (APA, 1994), which include such symptoms as tolerance, use in dangerous situations, trouble with the law, and interference with major obligations at work, school, or home during the past year.

Mental health service use is defined in the National Survey on Drug Use and Health (NSDUH) for adults aged 18 or older as receiving treatment or counseling for any problem with emotions, nerves, or mental health in the 12 months before the interview in any inpatient or outpatient setting, or the use of prescription medication for treatment of any mental or emotional condition that was not caused by the use of alcohol or drugs.

Number of individuals enrolled in substance use treatment refers to the number of clients in treatment at alcohol and drug abuse facilities (public and private) throughout the 50 states, the District of Columbia, and other U.S. jurisdictions.

Opioid use disorder is defined as heroin use disorder or prescription pain reliever use disorder using diagnostic criteria specified within the DSM-IV (APA, 1994), which include such symptoms as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference with major obligations at work, school, or home during the past year.

Definitions

Prescription pain relievers include the following subcategories of pain relievers (examples of specific pain relievers shown in parentheses): *hydrocodone products* (e.g., Vicodin®, Lortab®, Norco®, Zohydro® ER, generic hydrocodone); *oxycodone products* (e.g., OxyContin®, Percocet®, Percodan®, Roxicodone®, generic oxycodone); *tramadol products* (e.g., Ultram®, Ultram® ER, Ultracet®, generic tramadol, generic extended-release tramadol); *codeine products* (e.g., Tylenol® with codeine 3 or 4, generic codeine pills); *morphine products* (e.g., Avinza®, Kadian®, MS Contin®, generic morphine, generic extended-release morphine); *fentanyl products* (e.g., Duragesic®, Fentora®, generic fentanyl); *buprenorphine products* (e.g., Suboxone®, generic buprenorphine, generic buprenorphine plus naloxone); *oxymorphone products* (e.g., Opana®, Opana® ER, generic oxymorphone, generic extended-release oxymorphone); Demerol®; *hydromorphone products* (e.g., Dilaudid® or generic hydromorphone, Exalgo® or generic extended-release hydromorphone); methadone; or any other prescription pain reliever.

Prescription pain reliever misuse is defined as prescription pain reliever use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor.

Serious mental illness (SMI) is defined in NSDUH as adults aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified in the DSM-IV and has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities. SMI estimates are based on a predictive model applied to NSDUH data and are not direct measures of diagnostic status. The estimation of SMI covers any mental disorders that result in serious impairment in functioning such as major depression and bipolar disorders. However, NSDUH data cannot be used to estimate the prevalence of specific mental disorders in adults. Also, it should be noted that SAMHSA has recently updated the definition of SMI for use in mental health block grants to include mental disorders as specified in the DSM-IV (APA, 1994).

Substance use disorder is defined as dependence on or abuse of alcohol, illicit drugs (e.g., marijuana, cocaine, hallucinogens, heroin, or inhalants), or psychotherapeutics (e.g., prescription pain relievers, sedatives, tranquilizers, or stimulants) in the past 12 months based on assessments of individual diagnostic criteria from the DSM-IV (APA, 1994), which include such symptoms as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference with major obligations at work, school, or home during the past year.

References and Sources

American Psychiatric Association (APA). (1994). *Diagnostic and statistical manual of mental disorders* (DSM-IV) (4th ed.). Washington, DC: Author.

American Psychiatric Association (APA). (2013). *Diagnostic and statistical manual of mental disorders* (DSM-5) (5th ed.). Arlington, VA: Author.

The National Survey on Drug Use and Health (NSDUH) is an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). NSDUH is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the U.S. civilian, noninstitutionalized population aged 12 years or older and includes mental health issues and mental health service utilization for adolescents aged 12–17 and adults aged 18 or older. Conducted by the federal government since 1971, NSDUH collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence. The data used in this report are based on information obtained from approximately 67,500 individuals aged 12 years or older per year in the United States. Additional information about NSDUH is available at https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health.

The National Survey of Substance Abuse Treatment Services (N–SSATS) is an annual census designed to collect information from all public and private treatment facilities in the United States that provide substance abuse treatment. The objectives of N–SSATS are to collect multipurpose data that can be used to assist SAMHSA and state and local governments in assessing the nature and extent of services provided and in forecasting treatment resource requirements, to update SAMHSA's Inventory of Behavioral Health Services, to analyze general treatment services trends, and to generate the Behavioral Health Treatment Services Locator (https://findtreatment.samhsa.gov/). Data presented in this report reflect all publicly available data in N–SSATS reports at the time of the writing of this report and may present data previously unavailable in prior barometer reports. Additional information about N–SSATS is available at https://www.samhsa.gov/data/all-reports.

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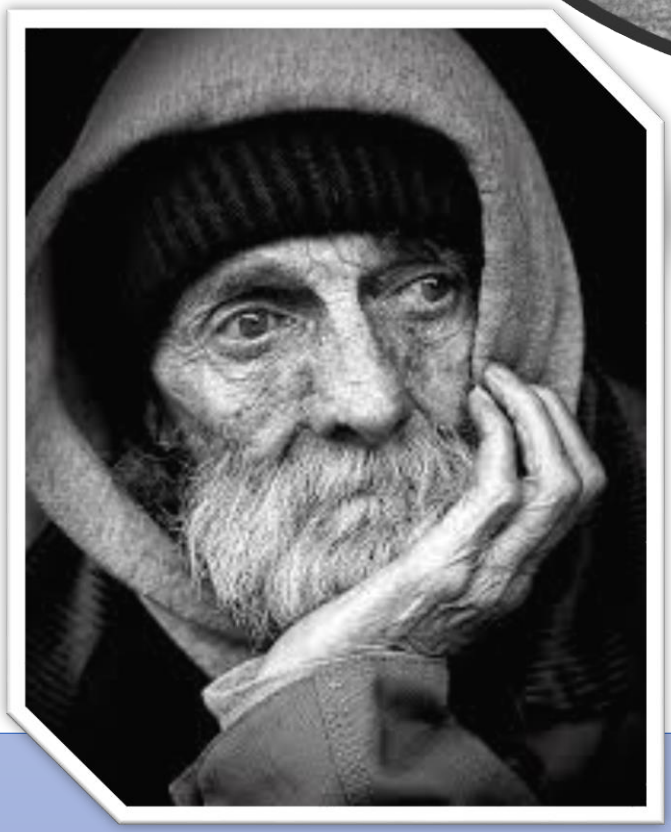
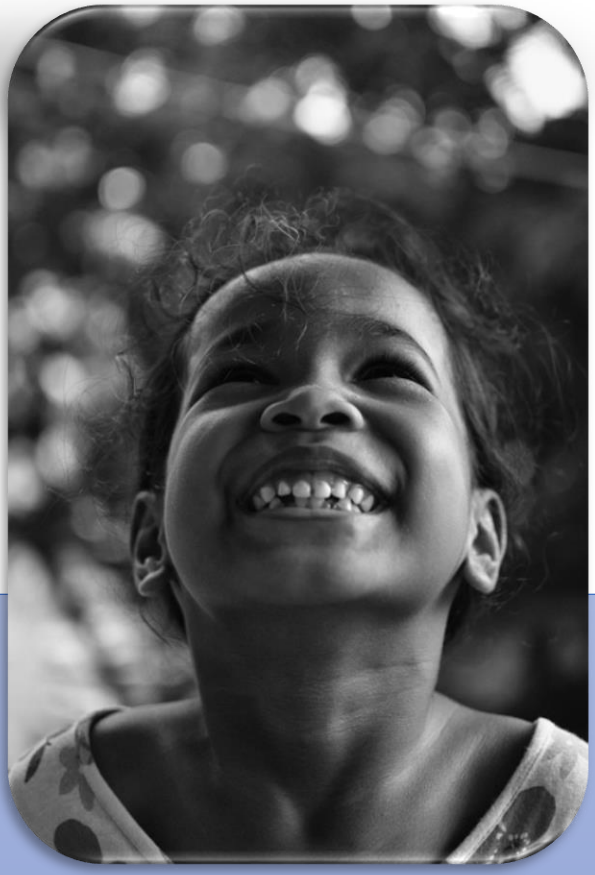
Substance Abuse and Mental Health Services Administration
Center for Behavioral Health Statistics and Quality

SAMHSA
Substance Abuse and Mental Health Services Administration

BEHAVIORAL HEALTH IN RHODE ISLAND (2019):
STATE EPIDEMIOLOGICAL PROFILE





Samantha R. Rosenthal, PhD, MPH
Peter Medici, BS Candidate

On Behalf of the State Epidemiological Outcomes Workgroup
January 2020

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Introduction

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), the single state authority for substance misuse prevention and treatment and the state mental health authority, established the State Epidemiological Outcomes Workgroup (SEOW). BHDDH and SEOW report results of its activities to the Rhode Island Governor's Council on Behavioral Health. BHDDH continues its existing relationship with various stakeholders throughout the state including the Rhode Island Department of Health, the Brown University School of Public Health, the University of Rhode Island (URI), and other community-based organizations.

The objectives of the SEOW are to: (1) Develop a set of key indicators, micro level to macro level, to describe the magnitude and distribution of substance use, misuse, 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, misuse, 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, misuse, 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, misuse and consequences, mental illness, and relevant multilevel risk and protective factors.

As such, the SEOW mission is reflected in this Profile, which offers integrated and comprehensive data on magnitude and distribution of substance use (i.e., alcohol, tobacco, and other drugs) and mental health indicators for both adults and youth in the state of Rhode Island as compared to the United States. Additionally, Rhode Island was compared to neighboring and regional states in New England (CT, ME, MA, NH, RI, VT) and the Northeast (NY, NJ, PA). The report is designed to be used as a resource by various RI state agencies, such as the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH); Rhode Island Student Assistance Services, the State Epidemiological Outcomes Workgroup (SEOW); the Regional Prevention Task Forces; and the University of Rhode Island evaluation team.

The Profile is guided by an outcomes-based framework, and as such, identifies specific areas of need, as well as potential risk and protective factors, from several ecological levels. Data summarized in the Profile can be used 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 by providing a comprehensive set of key indicators describing the magnitude and distribution of:

- Substance use consumption patterns (e.g. alcohol, tobacco, and other drugs), as well as their adverse consequences across various sub-populations (e.g. youth, adult, racial/ethnic, gender, sexual orientation, education, income).
- Mental and behavioral health outcomes including injury and violence.
- Potential risk and protective factors associated with substance use and mental illness.

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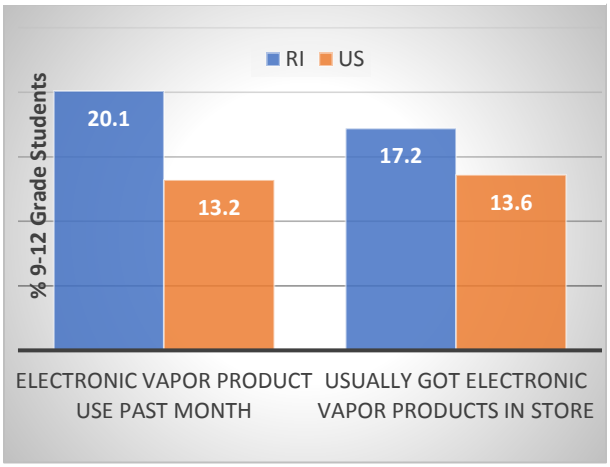
Key Findings

Tobacco & Electronic Vapor Products

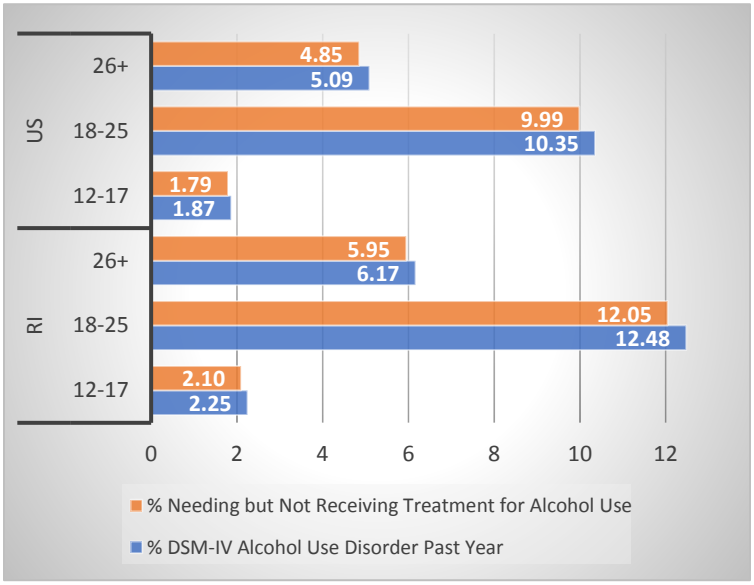
The use of cigarettes and other non-electronic tobacco products among Rhode Island high school students has been consistently lower than the nation since 2011. Yet, among those students who smoke cigarettes, RI students are much more likely to smoke 10 or more cigarettes per day than students across all other northeastern states. Adults and teens use tobacco and perceive smoking risk as expected given national estimates. Vaping rates are also as expected among RI adults, but **past month electronic vapor product use among RI high school students now surpasses the national average by 50%,** with 20.1% of students reporting use, among the highest rates in the northeast. Also, **underage high school students using vapor products in RI are much more likely to purchase these products in store** than those in other northeastern states and across the nation.

Figure 1. High School Student Vaping



Source: YRBSS 2017

Figure 2. Alcohol Disorder and Unmet Need



Source: NSDUH 2016-2017

Alcohol

The risky use of alcohol among RI high school students has been comparable to or consistently lower than the nation since 2011. Despite expected perceptions of harm from drinking across all ages 12+ years in RI, **rates of alcohol use among both adults and teens, alcohol use disorder, and unmet treatment need are all well above national levels**, yet comparable to other northeastern states. Similarly, alcohol use and binge drinking among 12-20 year old's in RI exceed the nation, with only Massachusetts and Vermont surpassing these rates in the northeast.

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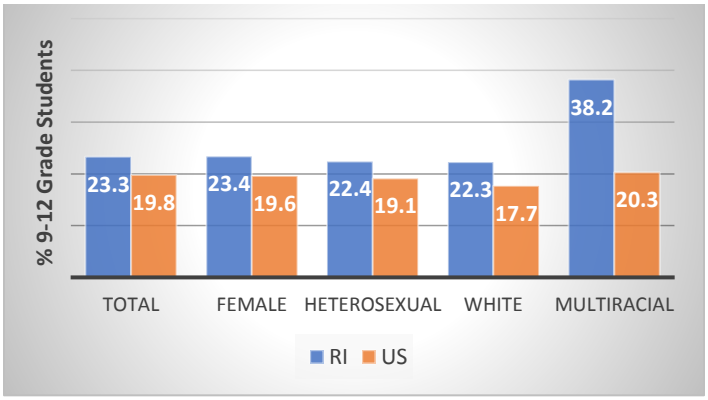
Marijuana

Figure 3. Past Month Marijuana Use



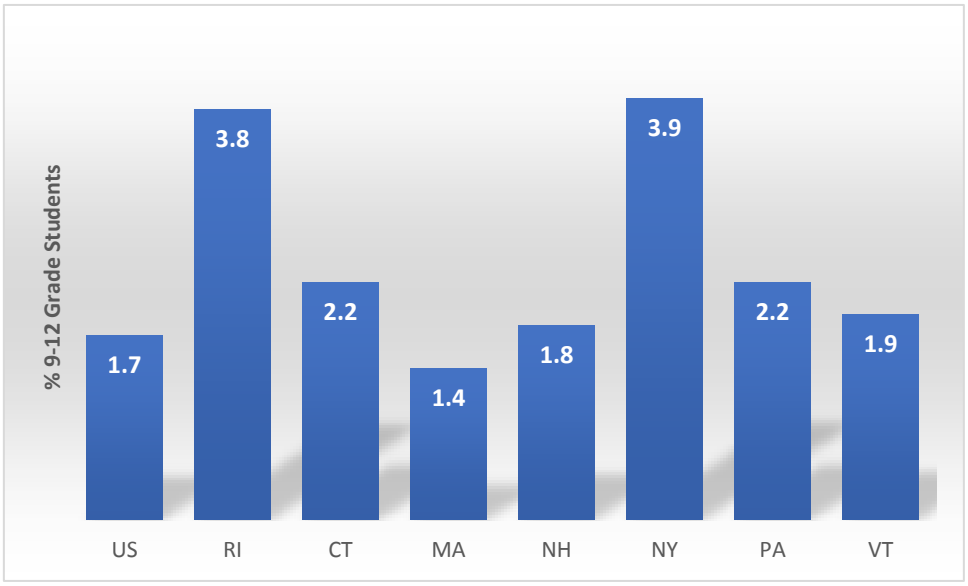
Source: YRBSS 2017

Rhode Island high school students are just as likely to ever try marijuana or synthetic marijuana or initiate marijuana use early as other students across the nation. However, RI students have an 18% increased risk of past month marijuana use above the national average, with a prevalence of 23.3%--a prevalence comparable to other neighboring states. **Particular students more likely to report current marijuana use relative to the nation include female, heterosexual, white, and multiracial students.** Rhode Island residents of all ages 12+ years are more likely to currently use marijuana than others in the US, with almost 32% of 18-25 year olds reporting past month use. In addition, **Rhode Islanders aged 18+ years old perceive less harm from marijuana than the nation**, though these perceptions are consistent with other states in the northeast.

Heroin & Opioids

While pain reliever misuse and perceptions of harm from heroin among Rhode Islanders aged 12+ years are consistent with the US population, heroin use continues to be a concern. **Since 2015 RI high school student prevalence of ever using heroin has been about twice the national prevalence and is among the highest in the northeast.** Similarly, past year heroin use in RI has exceeded the nation for all age groups 12+ years since 2014. Finally, the opioid overdose death rate in RI continues to increase, but is consistent with rates in other states in New England.

Figure 4. Ever Used Heroin



Source: YRBSS 2017

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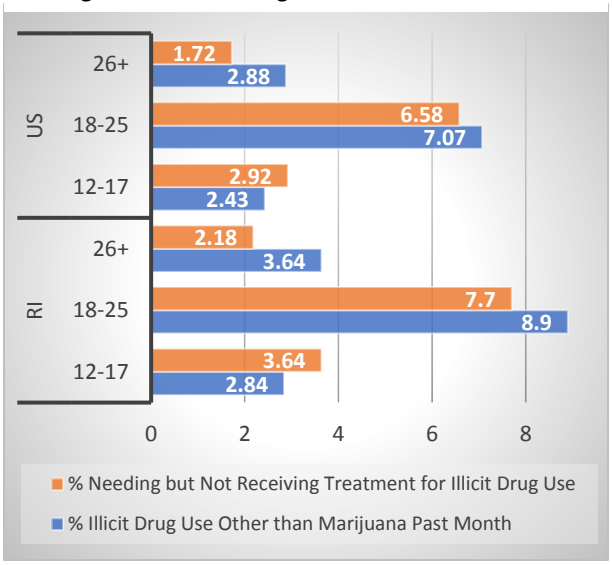
Figure 5. Illicit Drug Use and Unmet Need



Source: NSDUH 2016-2017

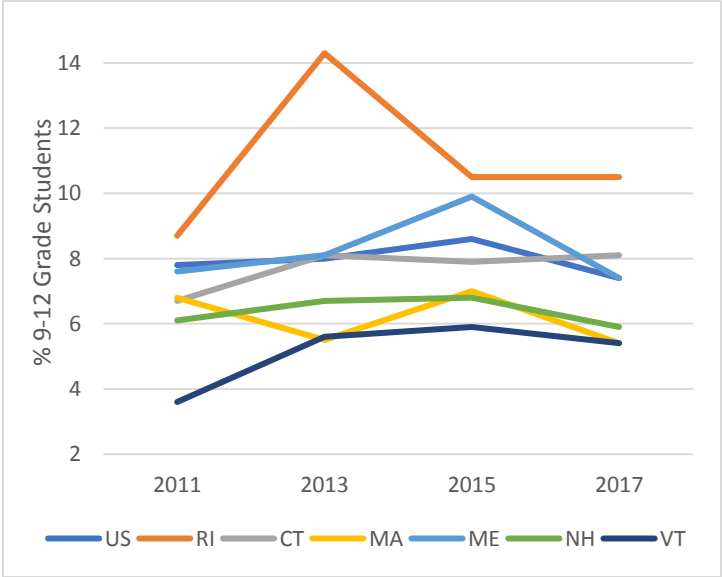
Other Drugs & Consequences

High school students in RI, particularly males, have concerning rates of steroid misuse relative to the nation (4.6% vs. 2.9%, respectively), but have expected rates of cocaine, ecstasy, and prescription pain medication misuse. Rhode Island residents (12+) have excessive rates of illicit drug use other than marijuana with some of the highest rates in the northeast for 12-17 and 26+ year olds. **Rhode Islanders also have concerning rates of needing but not receiving treatment for their drug use, with the highest prevalence in the northeast for 12-17 year olds in 2016-2017 (3.64%).** Despite expected perceptions of harm from cocaine among Rhode Islanders, cocaine use in the past year is concerning for all age groups (12+). Substance- related mortality rates in RI are comparable to the national average for: malignant neoplasms, circulatory system disease, chronic lower respiratory disease, alcoholic liver disease, and alcohol-induced. However, the **drug-induced death rate in RI continues to increase and surpass the national average**.

Mental Health

Mental health outcomes in RI tend to be comparable to the nation. However, **RI high school students are more likely to attempt suicide (10.5%) or suffer injury from attempted suicide (3.8%) and these are among the highest rates in the region**. RI male high school students, in particular, have this excess risk. Rhode Island residents (12+) are more likely to receive mental health services in the past year than national estimates. **Yet, adults in RI (18-64), males, and racial/ethnic minorities are more likely to suffer from frequent mental distress.** Finally, mortality from mental and behavioral disorders in RI continues to be significantly higher than the nation.

Figure 6. Past Year Attempted Suicide



Source: YRBSS 2017

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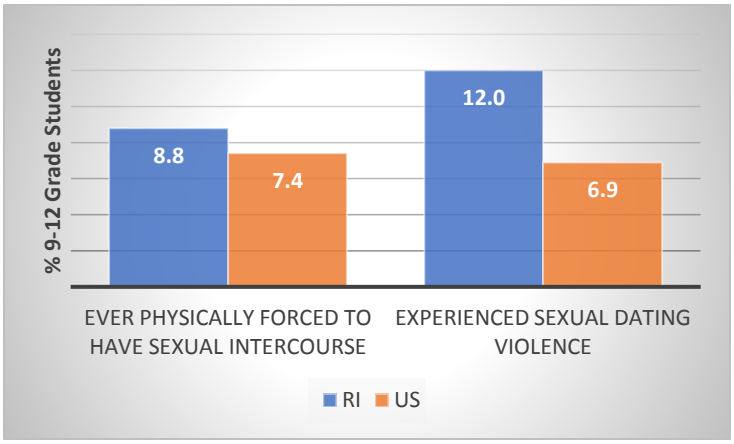
Injury & Violence

The traffic fatality rate and percent of distracted drivers in fatal motor vehicle crashes in RI are consistently below the national average, as are the RI crime rates, suicide rates, and homicide rates. Rhode Islanders are comparable to others across the nation in terms of texting and driving, wearing their seat belt, and being bullied. Yet, **RI has twice the proportion of drivers under the influence in fatal crashes as the national average**, second only to New Hampshire in the northeast.

Figure 7. Sexual Violence among High School Students



Source: YRBSS 2017

RI high school students are more likely to carry a weapon at school, physically fight on school property, and suffer from a sports concussion relative to the nation and other northeastern states. In particular, non-white students are more likely to carry a weapon at school, while male, sexual minority, and non-white students are more likely to engage in physical fights at school relative to the nation. Male, gay or lesbian, and non-white students are more likely to suffer from a sports concussion than those nationally. **RI has the highest rates of sexual violence among high school students in the northeast, with 8.8% having ever been physically forced to have sexual intercourse and 12.0% experiencing sexual dating violence.** Though females have a higher prevalence, RI male, heterosexual, Hispanic, and white students were more likely to have been physically forced to have sexual intercourse than those across the nation. Finally, despite having comparable child maltreatment fatality rates to the nation, RI continues to exceed the national average for child maltreatment rates.

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Methods

Sources of data included in the Profile are those that provide behavioral health outcomes, with valid and reliable national estimates over time, as well as regional or state comparisons. The sources of data compiled in the Profile are often publicly available, yet the Profile offers several distinct advantages by:

- Combining, summarizing, and presenting all relevant data in a unified, easy-to-read manner.
- Providing national and regional comparisons for the selected key indicators.
- Providing temporal trends for the selected key indicators.
- Providing sub-population analysis for indicators identified as concerning.

A full list of data sources utilized in the report can be found in the Appendix. This report is organized by substantive area in following seven topics: Rhode Island demographic and sociodemographic context, tobacco, electronic vapor products, alcohol, marijuana, heroin & opioids, other drugs & consequences, mental health, and injury & violence.

This report relies heavily on comparison of state to national averages. Consistent with past reports, indicators were deemed **CONCERNING** if Rhode Island exceeded the national average by 15% or more based on the most recent data or **PROMISING** if Rhode Island was 15% or more below the national average based upon the most recent data. When any indicator was identified as **CONCERNING**, sub-population analyses were investigated by region, age group, gender, sexual orientation, race/ethnicity, education, and income as data availability allowed. Within each substantive topic of the report, indicators were categorized as:

- **Sustained Progress** if the two most recent data points were identified as **PROMISING**.
- **Recent Progress** if the most recent data indicated substantial improvement compared to the prior year data point (e.g., prior data were **CONCERNING** but most recent data point was **PROMISING**, or the prior year data point was comparable to the nation, but most recent data point was **PROMISING**);
- **Comparable to the Nation** if the most recent data for RI were within 14% of the US values;
- **New Concern** if the most recent data point was identified as **CONCERNING** while the prior data point was not, or an indicator newly available was identified as **CONCERNING**;
- **Continuing Concern** if the two most recent data points were identified as **CONCERNING**.

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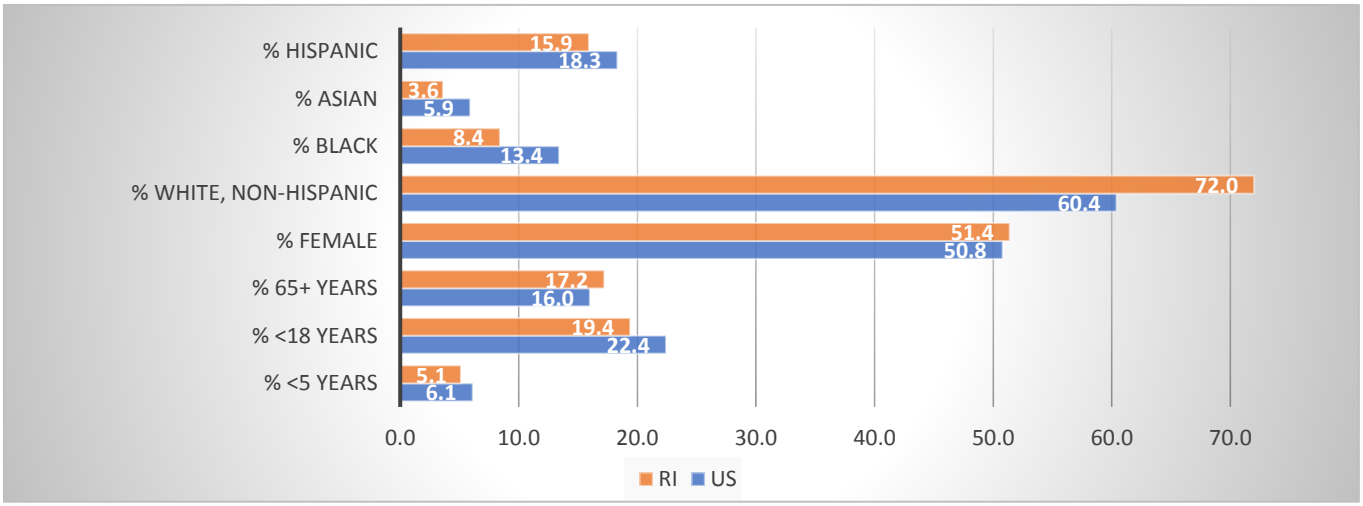
Demographics

Tables

Rhode Island (RI) is located in the New England region of the Northeast of the United States. RI is geographically the smallest US state, bordering Massachusetts (MA) to the north and east and Connecticut (CT) to the west. The 2018 Census Bureau estimates the population of RI at 1,057,315, only a 0.4% increase since 2010, with the majority of the population being ethnically/racially white, non-Hispanic. Rhode Island also has greater population density than the broader United States, ranked third in the country after the District of Columbia and New Jersey.

Figure 1. RI vs. US Population by Age, Race/Ethnicity and Sex, 2018



NOTE: Race groups include those reporting only one race; Hispanics may be of any race, so also are included in applicable race categories. American Indian/Alaska Native, Native Hawaiian/Other Pacific Islanders, and multiracial groups are excluded due to small sample size. *Source: United States Census Bureau, State & County QuickFacts*

Rhode Island has a slightly greater percent of foreign born and non-English primary speaking residents than the nation, with comparable population graduating high school, but more receiving a bachelor's degree or higher than the national average (33.0% vs. 30.9%, respectively). RI residents are slightly wealthier than the national average according to per capita income and median household income; however, poverty rates are higher in RI. Per capita income for RI was larger than the US at $33,315 compared to $31,177. Additionally, between 2013 and 2017, the median RI household income was $61,043, larger than the national median ($57,652). An estimated 12.9% of Rhode Islanders are below the poverty level, compared to 11.8% for the entire US. Rhode Islanders are slightly less likely than the nation to have broadband internet, with 86.4% versus 87.2%, respectively.

Table 1: RI vs. US Socioeconomic Characteristics

FOREIGN BORN AND LANGUAGE	US	RI
Foreign born persons, 2013-2017	13.4%	13.7%
Language other than English spoken at home, 2013-2017	21.3%	22.0%
EDUCATION		
High school graduate or higher age 25+, 2013-2017	87.3%	87.3%
Bachelor's degree or higher age 25+, 2013-2017	30.9%	33.0%
INCOME		
Per capita income past year (2017 dollars), 2013-2017	$31,177	$33,315
Median household income (2017 dollars), 2013-2017	$57,652	$61,043
Persons in poverty, 2018	11.8%	12.9%
OTHER		
Households with broadband internet, 2013-2017	87.2%	86.4%

Source: United States Census Bureau, State & County QuickFacts

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Given how small RI is, there is a relatively small civilian labor force of 560,000. This workforce is comparable to other small New England states like Maine, New Hampshire and Vermont. Unemployment in RI (3.6%) is comparable to other northeastern states.

As the poverty rate and unemployment have decreased, there have also been decreases in homelessness in RI from 2007 to 2018 of about 20%, and only 5% of those homeless (10 per 10,000) are unsheltered. Among those homeless in RI, about 70% are individuals, while 30% are people in families. Chronically homeless individuals, those with a disability who have been continuously homeless for more than a year or have had at least four episodes of homelessness equally a combined total of more than a year over the last three years, are more common in RI (22 per 100,000) than all other northeastern states except New York. RI has fewer homeless unaccompanied youth than all states in the northeast but is relatively consistent with other states in terms of homeless veterans.

Table 2: RI vs. Region Labor Force Data for October, 2019

	RI	CT	MA	ME	NH	NJ	NY	PA	VT
Civilian Labor Force (hundred thousand persons, seasonally adjusted)	5.6	19.2	38.5	6.9	7.7	44.8	95.2	65.2	3.4
Unemployment (% of labor force, seasonally adjusted)	3.6	3.6	2.9	2.8	2.6	3.2	4.0	4.2	2.2

Source: U.S. Bureau of Labor Statistics (BLS)

Table 3: RI vs. Region Homelessness per 10,000 in 2018

	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
Change in Total Homelessness (%), 2007-2018	-14.6	-19.8	-11.3	32.7	-4.6	-35.5	-45.7	46.8	-16.7	24.7
Overall Homeless	17	10	11	29	19	11	11	47	11	21
% Unsheltered	35	5	15	5	4	11	17	5	13	6
Homeless Individuals	11	7	6	10	11	6	7	20	6	12
Homeless People in Families	6	3	5	19	8	5	4	27	4	8
Chronically Homeless Individuals	2.7	2.2	0.8	2.0	1.5	1.0	1.4	3.0	1.0	2.2
Homeless Veterans	1.2	1.0	0.5	1.4	0.9	1.1	0.6	0.6	0.8	1.7
Homeless Unaccompanied Youth*	1.1	0.4	0.5	0.7	1.1	0.6	0.6	1.5	0.5	1.6
Homeless Parenting Youth*	0.3	0.2	0.2	0.9	0.2	0.2	0.3	1.4	0.3	0.5

NOTE: *Youth were defined as <25 years old. All rates were calculated using 2018 annual estimates of the resident population from U.S. Census Bureau, Population Division. *Source: United States Census Bureau, Annual Homeless Assessment Report (AHAR)*

At 5%, the proportion of the RI population that is uninsured is below the entire US (9%) and is comparable to most other states in the region. Compared to the US (49%), RI had a higher percentage of health insurance coverage by employer (51%).

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Table 4: RI vs. Region Health Insurance Coverage (%), 2017

	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
Uninsured	9	5	6	3	8	6	8	6	6	4
Employer	49	51	54	55	49	57	56	49	52	46
Other Private	7	6	6	5	7	6	6	6	6	5
Medicaid	21	24	20	24	18	19	17	26	20	28
Medicare	14	14	14	13	17	17	13	12	16	16
Other Public	1	1	1	1	2	1	1	1	1	1

Source: Kaiser Family Foundation estimates based on the Census Bureau's American Community Survey, 2008-2017.

For Medicare coverage, RI is comparable to the nation and other states in the region. Medicaid and the Children's Health Insurance Program (CHIP) commonly provides health coverage to nearly 60 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities (Centers for Medicare and Medicaid Services). Federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups as well (optional eligibility groups) (Centers for Medicare and Medicaid Services). RI expanded Medicaid in 2014 and enrollment has grown by 63% since, with 24% of the population enrolled.

The proportion aged 0-18 supported by Medicaid in RI (38%) was slightly lower than the national average (39%), but generally consistent with other states in the region; in RI, 21% of those on Medicaid are aged 19-64, well above the proportion nationally. Regarding the poverty level of those supported with expanded Medicaid coverage, RI covered a larger proportion of persons of higher income (under 100% of the federal poverty level) at 78%, the highest proportion in the region and much higher than the overall US at 61%.

Table 5: RI vs. Region Medicaid Coverage (%) among Nonelderly, 2017

	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
Age										
0-18	39	38	34	35	31	32	31	41	36	54
19-64	15	21	17	22	14	10	13	23	16	24
Federal Poverty Level										
Under 100%	61	78	71	76	66	68	61	74	67	72
100-199%	43	55	56	65	46	41	48	56	47	68
200-399%	18	24	24	31	12	19	19	26	17	32
400%+	5	7	6	8	5	4	5	8	5	8
vRace/Ethnicity										
White	16	18	13	17	18	15	11	18	16	30
Black	34	39	35	42	31	20	31	38	40	56
Hispanic	32	49	43	56	31	27	30	43	41	32

NOTE: USA excludes Puerto Rico. Medicaid includes those covered by Medicaid, Medical Assistance, Children's Health Insurance Plan (CHIP) or any kind of government-assistance plan for those with low incomes or a disability, as well as those who have both Medicaid and another types of coverage, such as dual eligible who are also covered by Medicare.
Source: Kaiser Family Foundation estimates based on the Census Bureau's American Community Survey 2008-2017

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Tobacco

Tables

Tobacco Indicator Performance

Tobacco Indicators		Data Source	Sustained Progress	Recent Progress	Comparable to the Nation	New Concern	Continuing Concern
Smoking Cigarettes 20+ Days Past Month		*YRBSS*					
Initial Tobacco Use Before Age 13		*YRBSS*					
Smoked Cigarettes Past Month		*YRBSS*					
Tobacco Use Past Month		*YRBSS*					
Smoked 10+ Cigarettes Per Day Past Month		*YRBSS*					
Smoked Cigarettes Daily Past Month		*YRBSS*					
Smokeless Tobacco Use Past Month		*YRBSS*					
Smoked Cigars Past Month		*YRBSS*					
Used Cigs, Cigars, Or Smokeless Past Month		*YRBSS*					
Ever Smoked a Cigarette		*YRBSS*					
Tobacco Use Past Month	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Perceived Risk of Smoking	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Cigarette Use Past Month	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Smoking Past Month		*BRFSS*					
Smokeless Tobacco Use Past Month		*BRFSS*					

Sustained Progress

High school students in Rhode Island fare better than the nation consistently since 2011 for several indicators, according to the YRBSS: smoking cigarettes 20+ days in the past month, initial use of tobacco before age 13, currently smoking cigarettes (past month), currently smoking cigarettes daily (past month), and having ever smoked a cigarette (Table 1). Most of these cigarette-related behaviors are also decreasing in prevalence in Rhode Island and across the nation like past month cigarette use, daily cigarette use, and having ever smoked a cigarette. According to the BRFSS, adults in RI have consistently reported less smokeless tobacco use than the nation (Table 6).

Comparable to the Nation

Despite decreasing prevalence, RI high school students fare comparably to the nation for reports of smokeless tobacco use (past month), smoking cigars in the past month, and using cigarettes, cigars, or smokeless tobacco in the past month (Table 1). According to the NSDUH, past month use of tobacco and past month use of cigarettes continues to decrease in Rhode Island and the nation over time. RI residents aged 12+ years continue to have comparable perceptions of risk from smoking (Table 5). According to the BRFSS, a similar trend can be seen for adult current smoking (past month) which has been consistently decreasing over time and continues to be comparable to the national average since 2011 (Table 6).

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New Concern

A newly collected indicator on the YRBSS in 2017 suggests RI high school students are significantly more likely to report past month tobacco use than the national average (Table 3). This is likely attributed to the use of electronic vapor products, since all other cigarette, cigar, and smokeless tobacco indicators are inconsistent. The increased prevalence among RI students relative to the nation remained across all gender, sexual orientation, and racial groups (Tables 3, 4). Also, RI prevalence is highest among all northeastern states with available data (Table 2).

Continuing Concern

The proportion of high school students who smoked more than 10 cigarettes per day exceeded the nation in 2013 through 2017, according to YRBSS (Table 2). While greater than national levels, smoking more than 10 cigarettes per day among Rhode Island high school smokers is also the highest level reported throughout the northeast region (Table 2). When examined by specific sub-populations, there was limited data availability due to small sample size.

Table 1: RI vs. US Tobacco Consumption among High School Students (%), 2011-2017

% of Students (grades 9-12) Reporting:	2011			2013			2015			2017		
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US
Smoking Cigarettes 20+ Days Past Month	4.4	6.4	**0.69**	3.1	5.6	**0.55**	1.5	3.4	**0.44**	1.7	2.6	**0.70**
Initial Tobacco Use Before Age 13	7.1	10.3	**0.69**	5.6	9.3	**0.60**	5.5	6.6	**0.83**	7.3	9.5	**0.80**
Smoked Cigarettes Past Month	11.4	18.1	**0.63**	8.0	15.7	**0.51**	4.8	10.8	**0.44**	6.1	8.8	**0.70**
Tobacco Use Past Month	--	--	--	--	--	--	--	--	--	25.9	19.5	**1.30**
Smoked 10+ Cigarettes Per Day Past Month	8.6	7.8	**1.10**	13.0	8.6	**1.51**	11.7	7.9	**1.48**	18.1	9.7	**1.90**
Smoked Cigarettes Daily Past Month	3.2	4.8	**0.67**	2.3	4.0	**0.58**	1.1	2.3	**0.48**	1.2	2.0	**0.60**
Smokeless Tobacco Use Past Month	5.7	7.7	**0.74**	7.0	8.8	**0.79**	5.3	7.3	**0.73**	5.0	5.5	**0.90**
Smoked Cigars Past Month	13.3	13.1	**1.01**	9.4	12.6	**0.75**	8.4	10.3	**0.81**	6.8	8.0	**0.90**
Used Cigarettes, Cigars, Or Smokeless Tobacco Past Month	21.4	25.5	**0.84**	17.3	24.0	**0.72**	13.3	18.5	**0.72**	11.9	14.0	**0.90**
Ever Smoked a Cigarette	35.0	44.7	**0.78**	29.7	41.1	**0.72**	22.4	32.3	**0.69**	19.5	28.9	**0.67**

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. Tobacco Use Past Month includes those who smoked cigarettes or cigars or used smokeless tobacco or an electronic vapor product on at least 1 day during the past 30 days. Smoked 10+ Cigarettes per Day Past Month is defined as smoking more than 10 cigarettes in a single day on any day they smoked in the past 30 days, among students who currently smoked cigarettes. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

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Table 2: RI vs. Region Tobacco Consumption among High School Students (%), 2011-2017

	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
Tobacco Use Past Month										
2017	19.5	**25.9**	--	24.6	22.5	--	--	19.3	18.7	18.9
Smoked 10+ Cigarettes Per Day Past Month										
2011	7.8	**8.6**	--	--	15.3	--	7.1	16.3	--	10.6
2013	8.6	**13.0**	--	--	12.7	13.7	12.5	15.7	--	--
2015	7.9	**11.7**	--	--	14.6	14.2	--	11.6	8.0	11.7
2017	9.7	**18.1**	--	--	11.7	11.8	--	10.7	5.9	11.9

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 3: RI vs. US Gender and Sexual Orientation Disparities in Tobacco Consumption (%), 2017

		Male	Female	Hetero-sexual	Gay or Lesbian	Bisexual	Gay, Lesbian, or Bisexual	Sexual Orientation Not Sure
	Tobacco Use Past Month							
2017	RI	29.7	20.9	24.3	40.4	33.1	34.7	32.6
	US	23.4	15.6	19.2	25.3	27.8	27.2	18.7
	RI/US Ratio	**1.27**	**1.34**	**1.27**	**1.60**	**1.19**	**1.28**	**1.74**
	Smoked 10+ Cigarettes Per Day Past Month*							
2017	RI	--	--	12.3	--	--	--	--
	US	11.7	6.5	8.1	6.5	5.5	5.7	39.6
	RI/US Ratio	--	--	**1.52**	--	--	--	--

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Sub-group data missing due to small sample size. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 4: RI vs. US Racial Disparities in Tobacco Consumption (%), 2017

		Asian	Black	Hispanic	White	Multiple Races
	Tobacco Use Past Month*					
2017	RI	--	17.2	21.7	28.5	24.7
	US	5.5	14.9	16.6	22.4	20.0
	RI/US Ratio	--	**1.15**	**1.31**	**1.27**	**1.24**
	Smoked 10+ Cigarettes Per Day Past Month*					
2017	RI	--	--	--	--	--
	US	--	--	8.4	8.3	--
	RI/US Ratio	--	--	--	--	--

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Sub-group data missing due to small sample size. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

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Table 5: RI vs. US Tobacco Indicators (%) by Age Group, 2013-2017

Age Group	12+			12-17			18-25			26+		
	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio
Tobacco Use Past Month												
2013-2014	24.19	25.36	**0.95**	6.80	7.42	**0.92**	35.37	36.04	**0.98**	23.98	25.72	**0.93**
2014-2015	23.45	24.56	**0.95**	5.86	6.50	**0.90**	34.58	32.02	**1.08**	23.29	25.14	**0.93**
2015-2016	24.16	23.72	**1.02**	6.17	5.66	**1.09**	33.62	31.48	**1.07**	24.34	24.58	**0.99**
2016-2017	22.31	22.99	**0.97**	4.90	5.10	**0.96**	28.22	29.52	**0.96**	23.84	24.04	**0.99**
Perceived Risk of Smoking*												
2013-2014	74.02	71.06	**1.04**	66.58	65.28	**1.02**	70.85	66.43	**1.07**	75.43	72.55	**1.04**
2015-2016	74.94	72.80	**1.03**	68.14	68.71	**0.99**	69.71	68.29	**1.02**	76.61	74.04	**1.03**
2016-2017	73.68	72.21	**1.02**	68.47	68.24	**1.00**	68.66	67.57	**1.02**	75.12	73.44	**1.02**
Cigarette Use in the Past Month*												
2013-2014	20.10	21.05	**0.95**	4.72	5.25	**0.90**	28.01	29.49	**0.95**	20.29	21.53	**0.94**
2015-2016	19.19	19.23	**1.00**	3.69	2.80	**1.31**	24.92	25.12	**0.99**	19.79	20.09	**0.99**
2016-2017	17.66	18.47	**0.96**	2.97	3.29	**0.90**	21.15	22.90	**0.92**	18.56	19.54	**0.95**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *No data available for 2014-2015. *Source: National Survey on Drug Use and Health (NSDUH)*

Table 6: RI vs. US Adult Tobacco Indicators (%), 2013-2018

	2013	2014	2015	2016	2017	2018
Smoking Past Month						
RI	17.4	16.3	15.5	14.4	15.0	14.6
US	19.0	18.1	17.5	17.0	17.1	16.1
RI/US Ratio	**0.92**	**0.90**	**0.89**	**0.85**	**0.88**	**0.91**
Smokeless Tobacco Use Past Month						
RI	1.9	2.0	2.0	1.5	2.1	1.8
US	4.3	4.2	4.0	4.0	4.0	4.2
RI/US Ratio	**0.44**	**0.48**	**0.50**	**0.38**	**0.53**	**0.43**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Behavioral Risk Factor Surveillance Survey (BRFSS)*

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Electronic Vapor Products

Tables

Electronic Vapor Product Indicator Performance

Electronic Vapor Product Indicators	Data Source	Sustained Progress	Recent Progress	Comparable to the Nation	New Concern	Continuing Concern
Ever Used Electronic Vapor Products	*YRBSS*					
Electronic Vapor Product Use Past Month	*YRBSS*					
Current Frequent Electronic Vapor Product Use	*YRBSS*					
Current Daily Electronic Vapor Product Use	*YRBSS*					
Usually got Electronic Vapor Products in Store	*YRBSS*					
Ever E-Cig Use	*BRFSS*					
E-Cig Use Past Month	*BRFSS*					

Comparable to the Nation

RI high school students fare comparably to the nation for reports of having ever used electronic vapor products, current frequent vapor product use (past month), and current daily vapor product use (past month) (Table 1). According to the BRFSS data, a similar trend can be seen for adults having ever used e-cigarettes or current use (past month) (Table 5).

New Concern

Data pertaining to electronic vapor product use was not collected in the YRBSS until 2015 nor the BRFSS until 2016. One newer relevant indicator was introduced to the YRBSS in 2017, whether a student usually got their electronic vapor products in a store. The YRBSS 2017 data suggest RI high school students are significantly more likely to engage in electronic vapor product use in the past month and are more likely to get their electronic vapor products in a store (Table 3). Though all racial/ethnic, gender, and sexual orientation groups have higher prevalence than the nation for past month electronic vapor product use, RI prevalence is relatively consistent with other northeastern states (Table 2). However, RI has the highest percent of high school students reporting buying their products in store than all other northeastern states with data available. When examined by specific sub-populations, there was limited data availability due to small sample size.

Table 1: RI vs. US Electronic Vapor Product Use among High School Students (%), 2015-2017

% of Students (grades 9-12) Reporting:	2015			2017		
	RI	US	RI/US Ratio	RI	US	RI/US Ratio
Ever Used Electronic Vapor Products	40.9	44.9	**0.91**	40.3	42.2	**0.95**
Electronic Vapor Product Use Past Month	19.3	24.1	**0.80**	20.1	13.2	**1.53**
Current Frequent Electronic Vapor Product Use	2.1	3.0	**0.70**	3.7	3.3	**1.12**
Current Daily Electronic Vapor Product Use	1.7	2.0	**0.85**	2.7	2.4	**1.13**
Usually got Electronic Vapor Products in Store	--	--	**--**	17.2	13.6	**1.26**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. Current Frequent Vapor Product Use Past Month includes using e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on 20 or more days during the 30 days**.** Usually Got Electronic Vapor Products in Store includes purchasing e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, or hookah pens at a convenience store, supermarket, discount store, gas station, or vape store, during the past 30 days, among students who currently used electronic vapor products and who were aged <18. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

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Table 2: RI vs. Region Electronic Vapor Product Use among High School Students (%), 2015-2017

	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
Electronic Vapor Product Use Past Month										
2015	24.1	**19.3**	--	23.7	16.8	25.0	--	21.7	24.1	15.3
2017	13.2	**20.1**	--	20.1	15.8	23.8	--	14.5	11.3	12.0
Usually got Electronic Vapor Products in Store										
2017	13.6	**17.2**	--	--	6.3	10.3	--	--	12.5	7.8

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 3: RI vs. US Gender and Sexual Orientation Disparities in Electronic Vapor Product Use (%), 2017

		Male	Female	Hetero-sexual	Gay or Lesbian	Bisexual	Gay, Lesbian, or Bisexual	Sexual Orientation Not Sure
	Electronic Vapor Product Use Past Month							
2017	RI	22.3	17.0	20.1	26.5	19.4	21.1	17.7
	US	15.9	10.5	13.2	14.5	18.5	17.5	10.8
	RI/US Ratio	**1.40**	**1.62**	**1.52**	**1.83**	**1.05**	**1.21**	**1.64**
	Usually got Electronic Vapor Products in Store*							
2017	RI	20.3	12.9	18.3	--	10.5	9.5	--
	US	15.6	10.8	14.1	5.9	11.6	10.5	21.3
	RI/US Ratio	**1.30**	**1.19**	**1.30**	**--**	**0.91**	**0.90**	**--**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Sub-group data missing due to small sample size. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 4: RI vs. US Racial Disparities in Electronic Vapor Product Use (%), 2017

		Asian	Black	Hispanic	White	Multiple Races
	Electronic Vapor Product Use Past Month*					
2017	RI	--	12.3	16.2	22.7	19.8
	US	3.7	8.5	11.4	15.6	12.9
	RI/US Ratio	--	**1.45**	**1.42**	**1.46**	**1.53**
	Usually got Electronic Vapor Products in Store*					
2017	RI	--	--	--	**17.9**	--
	US	--	**14.5**	**10.8**	**14.8**	--
	RI/US Ratio	--	--	--	**1.21**	--

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Sub-group data missing due to small sample size. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 5: RI vs. US Adult E-Cig Indicators (%), 2016-2017

	2016	2017
Ever E-Cig Use		
RI	20.8	19.7
US	21.9	20.7
RI/US Ratio	**0.95**	**0.95**
E-Cig Use Past Month		
RI	4.5	4.9
US	4.7	4.6
RI/US Ratio	**0.96**	**1.07**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Behavioral Risk Factor Surveillance Survey (BRFSS)*

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Alcohol

Tables

Alcohol Indicator Performance

Alcohol Indicators		Data Source	Sustained Progress	Recent Progress	Comparable to the Nation	New Concern	Continuing Concern
Alcohol Use Past Month		*YRBSS*					
Binge Drinking Past Month		*YRBSS*					
Initial Alcohol Use Before Age 13		*YRBSS*					
Rode in Car with Drinking Driver Past Month		*YRBSS*					
Ever Drank Alcohol		*YRBSS*					
Source of Alcohol		*YRBSS*					
Alcohol Use Past Month	**Age 12-17**	*NSDUH*					
	Age 18-25						
	Age 26+						
DSM-IV Alcohol Use Disorder Past Year	**Age 12-17**	*NSDUH*					
	Age 18-25						
	Age 26+						
Needing but Not Receiving Treatment for Alcohol	**Age 12-17**	*NSDUH*					
	Age 18-25						
	Age 26+						
Perception of Great Risk of Having 5+ Drinks Once or Twice a Week	**Age 12-17**	*NSDUH*					
	Age 18-25						
	Age 26+						
Alcohol Use Past Month (Age 12-20)		*NSDUH*					
Binge Drinking Past Month (Age 12-20)		*NSDUH*					
Alcohol Use Past Month		*BRFSS*					
Binge Drinking Past Month		*BRFSS*					
Drinking and Driving		*BRFSS*					

Sustained Progress

Rhode Island continues to fare better than the nation for high school student past month alcohol use, binge drinking (past month), initial use of alcohol before age 13, and having ever drank alcohol since 2011. The prevalence of high school student past month alcohol use and binge drinking past month are decreasing in Rhode Island and across the nation (Table 6).

Recent Progress

Having previously been comparable to the nation, RI high school student reports of riding with a drinking driver (past month) recently improved relative to the US in 2017 YRBS data. Prevalence of riding with a drinking driver in the past month has been declining in RI and the nation since 2011 (Table 1).

Comparable to the Nation

In 2017, Rhode Island high school student reports of usually obtaining the alcohol they drank by someone giving it to them in the past 30 days were comparably prevalent to the national average (Table 1). NSDUH data regarding perception of harm from having 5+ drinks once or twice a week suggest RI resident perceptions for all age groups 12+ years are similar to national perceptions (Table 2). Annual BRFSS data show alcohol use (past month), binge drinking (past month) and

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drinking and driving among adults in Rhode Island has consistently been comparable to the nation since 2015 and prevalence has remained the same (Table 8).

New Concern

DSM-IV alcohol use disorder in the past year among 12-17 and 18-25 year olds exceed the United States average, according to data from 2016-2017 NSDUH (Table 2). However, these same rates are fairly consistent with other northeastern states (Table 4). Similarly, needing but not receiving treatment for alcohol use in the past month among 12-17 and 18-25 year olds exceeded the nation in the most recent year of data, but It is important to note that although this indicator meets the threshold for 15% increased prevalence in Rhode Island relative to the nation, the magnitude of the prevalence is very small and therefore the 15% increase may be negligible. Also, Rhode Island is comparable to other northeastern states when looking at needing but not receiving treatment for alcohol use in the past month among 12-17 and 18-25 year olds (Table 5).

Continuing Concern

Past month alcohol use among all age groups 12+ in RI exceed that of the nation for the past two years of available NSDUH data (2015-2016 and 2016-2017). While national alcohol use has steadily decreased over time, it has held relatively constant in RI and comparable to other northeastern states. DSM-IV alcohol use disorder in the past year among 26+ year olds exceed the United States average, according to data from 2015-2016 and 2016-2017 NSDUH (Table 2). This rate is also relatively high across the northeastern states, with only Massachusetts and Vermont exceeding RI (Table 4). Similarly, needing but not receiving treatment for alcohol use in the past month among 26+ year old Rhode Islanders exceeded the nation in the two most recent years of data; with only Massachusetts surpassing RI among the northeastern states (Table 5). Newly released indicators specific to 12 to 20-year olds, particularly alcohol use in the past month and binge drinking in the past month, suggest the Rhode Islanders consistently surpass the prevalence rates of the nation, exceeded only by Massachusetts and Vermont in the northeast (Table 6).

Table 1: RI vs. US Alcohol Indicators among High School Students (%), 2011-2017

% of Students (grades 9-12) Reporting:	2011			2013			2015			2017		
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US
Alcohol Use Past Month	30.0	38.7	**0.78**	30.9	34.9	**0.89**	26.1	32.8	**0.80**	23.2	29.9	**0.78**
Binge Drinking Past Month	18.3	21.9	**0.84**	15.3	20.8	**0.74**	12.8	17.7	**0.72**	11.2	13.5	**0.83**
Initial Alcohol Use Before Age 13	15.6	20.5	**0.76**	13.5	18.6	**0.73**	11.4	17.2	**0.66**	12.1	15.5	**0.78**
Rode in Car with Drinking Driver Past Month	21.9	24.1	**0.91**	20.1	21.9	**0.92**	17.5	20.0	**0.88**	13.9	16.5	**0.84**
Ever Drank Alcohol	62.0	70.8	**0.87**	-	66.2	**-**	52.5	63.2	**0.83**	50.4	60.4	**0.83**
Source of Alcohol*	-	40.0	**-**	32.2	41.8	**0.77**	39.2	44.1	**0.89**	38.2	43.5	**0.88**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source of Alcohol is defined as those who usually got the alcohol they drank by someone giving it to them during the past 30 days, among students who currently drank alcohol. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

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Table 2: RI vs. US Alcohol Indicators (%) by Age Group, 2013-2017

Age Group	12+			12-17			18-25			26+		
	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio
Alcohol Use Past Month												
2013-2014	57.82	52.42	**1.10**	13.21	11.55	**1.14**	65.30	59.6	**1.10**	61.28	56.18	**1.09**
2014-2015	59.37	52.18	**1.14**	13.23	10.58	**1.25**	65.22	58.96	**1.11**	63.25	56.04	**1.13**
2015-2016	61.03	51.70	**1.18**	12.10	9.60	**1.26**	67.35	58.30	**1.15**	65.05	55.60	**1.17**
2016-2017	60.15	51.21	**1.17**	11.01	9.54	**1.16**	67.96	56.74	**1.20**	63.88	55.22	**1.16**
DSM-IV Alcohol Use Disorder Past Year												
2013-2014	7.70	6.50	**1.18**	2.86	2.76	**1.04**	16.39	12.64	**1.30**	6.59	5.91	**1.18**
2014-2015	6.98	6.14	**1.14**	2.86	2.62	**1.09**	13.83	11.61	**1.19**	6.16	5.64	**1.09**
2015-2016	6.84	5.73	**1.19**	2.32	2.23	**1.04**	11.98	10.80	**1.10**	6.39	5.31	**1.20**
2016-2017	6.74	5.46	**1.23**	2.25	1.87	**1.20**	12.48	10.35	**1.21**	6.17	5.09	**1.21**
Needing but Not Receiving Treatment for Alcohol Use*												
2013-2014	7.07	6.20	**1.14**	2.74	2.62	**1.05**	15.5	12.22	**1.27**	5.95	5.61	**1.06**
2015-2016	6.56	5.48	**1.20**	2.22	2.15	**1.03**	11.03	10.47	**1.05**	6.20	5.05	**1.23**
2016-2017	6.49	5.22	**1.24**	2.10	1.79	**1.17**	12.05	9.99	**1.21**	5.95	4.85	**1.23**
Perception of Great Risk of Having 5+ Drinks Once or Twice a Week**												
2013-2014	37.37	40.79	**0.92**	37.91	39.09	**0.97**	29.07	33.36	**0.87**	39.36	42.27	**0.93**
2016-2017	39.63	44.50	**0.89**	41.58	43.83	**0.95**	34.74	37.53	**0.93**	40.31	45.72	**0.88**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *No data available for 2014-2015. **No data available for 2014-2015 or 2015-2016. *Source: National Survey on Drug Use and Health (NSDUH)*

Table 3: RI vs. Region Alcohol Use Past Month (%), by Age Group, 2014-2017

	Age Group	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2014-2015	**12+**	52.18	**59.37**	60.33	57.91	60.41	63.63	56.67	54.60	56.56	60.67
	12-17	10.58	**13.23**	13.61	12.21	12.47	13.12	13.88	12.57	11.34	13.16
	18-25	58.96	**65.22**	67.18	69.15	66.34	68.92	63.69	61.51	63.95	70.65
	26+	56.04	**63.25**	64.76	60.89	64.39	68.72	60.63	58.01	60.32	63.80
2015-2016	**12+**	51.70	**61.03**	59.09	59.17	56.97	63.54	53.56	54.65	55.78	60.17
	12-17	9.60	**12.10**	11.21	11.31	11.71	11.49	10.55	11.37	10.02	12.86
	18-25	58.30	**67.35**	67.37	69.57	64.86	69.23	61.28	62.60	62.27	69.00
	26+	55.60	**65.05**	63.34	62.48	60.35	68.17	57.40	57.99	59.72	63.39
2016-2017	**12+**	51.21	**60.15**	60.21	61.36	56.16	63.12	53.13	54.73	56.42	62.09
	12-17	9.54	**11.01**	11.42	12.72	11.24	11.30	10.87	9.85	10.06	13.62
	18-25	56.74	**67.96**	67.03	70.51	64.29	69.33	59.91	62.07	60.30	70.91
	26+	55.22	**63.88**	64.73	64.91	59.37	67.56	56.99	58.29	60.79	65.34

NOTE: Ratios greater than 1.14 indicate those indicators where RI exceeds the US average. Ratios less than 0.86 indicate those indicators where RI is below the US average. *Source: National Survey on Drug Use and Health (NSDUH)*

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Table 4: RI vs. Region DSM-IV Alcohol Use Disorder Past Year (%), Age Group, 2014-2017

	Age Group	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2014-2015	12+	6.14	**6.98**	6.90	6.70	5.33	7.20	5.72	6.41	6.45	6.95
	12-17	2.62	**2.86**	2.74	2.98	2.52	2.68	3.24	2.51	2.53	2.75
	18-25	12.64	**13.38**	13.00	12.58	12.07	14.12	11.42	11.59	13.26	15.50
	26+	5.91	**6.16**	6.40	6.07	4.69	6.59	5.15	5.95	5.79	5.89
2015-2016	12+	5.73	**6.84**	6.78	7.52	5.68	6.02	4.83	6.07	5.62	6.80
	12-17	2.23	**2.32**	2.82	2.56	2.42	2.28	2.19	2.21	2.12	2.60
	18-25	10.80	**11.98**	11.34	12.93	11.61	12.01	11.24	11.16	11.99	15.21
	26+	5.31	**6.39**	6.50	7.11	5.21	5.47	4.18	5.64	5.00	5.75
2016-2017	12+	5.46	**6.74**	6.10	7.12	5.62	6.13	4.71	5.67	4.97	7.26
	12-17	1.87	**2.25**	2.68	2.18	2.26	1.98	1.54	1.79	1.50	2.53
	18-25	10.35	**12.48**	11.18	14.10	10.50	12.94	11.11	9.80	10.32	16.03
	26+	5.09	**6.17**	5.68	6.44	5.29	5.52	4.13	5.41	4.52	6.20

NOTE: Ratios greater than 1.14 indicate those indicators where RI exceeds the US average. Ratios less than 0.86 indicate those indicators where RI is below the US average. *Source: National Survey on Drug Use and Health (NSDUH)*

Table 5: RI vs. Region Needing but Not Receiving Treatment for Alcohol Use (%), Age Group, 2015-2017

	Age Group	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2015-2016	12+	5.48	**6.56**	6.45	6.90	5.44	5.83	4.75	5.60	5.48	6.08
	12-17	2.15	**2.22**	2.62	2.33	2.39	2.17	2.17	2.09	2.03	2.39
	18-25	10.47	**11.03**	10.72	12.23	10.10	10.62	11.74	10.38	11.60	13.13
	26+	5.05	**6.20**	6.20	6.46	5.11	5.46	4.00	5.18	4.89	5.21
2016-2017	12+	5.22	**6.49**	5.77	6.70	5.41	5.95	4.61	5.43	4.90	6.65
	12-17	1.79	**2.10**	2.41	2.01	2.13	1.84	1.54	1.71	1.41	2.32
	18-25	9.99	**12.05**	10.21	13.13	9.80	11.83	11.08	9.36	10.19	14.44
	26+	4.85	**5.95**	5.44	6.09	5.14	5.46	4.00	5.19	4.46	5.72

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *No data available for 2014-2015. *Source: National Survey on Drug Use and Health (NSDUH)*

Table 6: RI vs. US Alcohol Indicators for Ages 12-20 Years, 2013-2017

	RI	US	RI/US Ratio
Alcohol Use Past Month			
2013-2014	31.07	22.76	**1.37**
2014-2015	28.02	21.57	**1.30**
2015-2016	24.94	19.83	**1.26**
2016-2017	25.70	19.50	**1.32**
Binge Drinking Past Month*			
2013-2014	19.26	22.76	**0.85**
2015-2016	15.98	12.71	**1.25**
2016-2017	17.22	12.00	**1.43**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *No data available for 2014-2015. *Source: National Survey on Drug Use and Health (NSDUH)*

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Table 7: RI vs. Region Alcohol Indicators (%) Ages 12-20 Years, 2014-2017

	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
Alcohol Use Past Month										
2014-2015	21.57	**28.02**	27.67	29.63	25.68	27.78	25.97	24.72	24.79	30.60
2015-2016	19.83	**24.94**	26.24	29.24	24.83	28.06	21.18	23.24	22.43	19.63
2016-2017	19.50	**25.70**	23.92	31.78	24.13	25.45	20.97	20.64	20.92	28.21
Binge Drinking Past Month*										
2015-2016	12.71	**15.98**	16.60	18.32	16.22	17.85	13.08	15.43	15.25	20.65
2016-2017	12.00	**17.22**	15.82	22.14	15.16	15.79	12.35	13.36	13.85	19.60

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *No data available for 2014-2015. *Source: National Survey on Drug Use and Health (NSDUH)*

Table 8: RI vs. US Adult Alcohol Consumption (%), 2013-2018

	Alcohol Use Past Month			Binge Drinking Past Month			Drinking and Driving		
	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio
2013	62.2	54.4	**1.14**	17.8	16.8	**1.06**	--	--	--
2014	63.2	53.1	**1.19**	18.4	16.0	**1.15**	4.0	3.3	**1.21**
2015	60.4	53.6	**1.13**	16.0	16.3	**0.98**	--	--	--
2016	61.8	54.0	**1.14**	15.8	16.9	**0.93**	4.3	4.0	**1.07**
2017	60.8	54.7	**1.11**	18.1	17.4	**1.04**	--	--	--
2018	60.8	53.5	**1.14**	16.5	16.2	**1.02**	3.1	3.2	**0.97**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Behavioral Risk Factor Surveillance Survey (BRFSS)*

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Marijuana

Tables

Marijuana Indicator Performance

Marijuana Indicators		Data Source	Sustained Progress	Recent Progress	Comparable to the Nation	New Concern	Continuing Concern
Marijuana Use Past Month		*YRBSS*					
Initial Marijuana Use Before Age 13		*YRBSS*					
Ever Use Synthetic Marijuana		*YRBSS*					
Ever Use Marijuana		*YRBSS*					
Marijuana Use Past Month	**Age 12-17**	*NSDUH*					
	Age 18-25						
	Age 26+						
Perceptions of Great Risk of Smoking Marijuana Once a Month	**Age 12-17**	*NSDUH*					
	Age 18-25						
	Age 26+						

Comparable to the Nation

Rates of high school student initial use of marijuana before age 13, having ever used synthetic marijuana, and having ever used marijuana are comparable to the nation and have been since 2011 (Table 1). Since 2011-2012, data consistently showed Rhode Islanders aged 12-17 years had a lower perception of harm of marijuana compared to the nation, but the most recent data from 2016-2017 suggest these perceptions are comparable to the national average (Table 5).

New Concern

In 2013 and 2015 past month marijuana use among RI high school students was comparable to the nation, yet 2017 data show RI prevalence at 23.3%, whilst the national average is 19.8% (Table 1). Those RI high school students more likely to use marijuana (past month) than their national counterparts are female, heterosexual or not sure of their sexual orientation, white or multiple races.

Continuing Concern

Marijuana use in the past month has been a concern in Rhode Island compared to the national average for the past 8 years across all age groups older than 12 years (Table 1). Prevalence of past month marijuana use among Rhode Islanders aged 12+ years ranks third highest in the northeast after Vermont and Maine (Table 6). Since 2011-2012, data have consistently shown that Rhode Islanders 18-25 years and 26+ years are less likely to perceive marijuana as harmful compared to the nation (Table 7).

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Table 1: RI vs. US Marijuana Use among High School Students (%), 2011-2017

% of Students (grades 9-12) Reporting:	2011			2013			2015			2017		
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US
Marijuana Use Past Month	26.3	21.3	**1.23**	23.9	23.4	**1.02**	23.6	21.7	**1.08**	23.3	19.8	**1.18**
Initial Marijuana Use Before Age 13	7.1	8.1	**0.88**	6.8	8.6	**0.79**	6.7	7.5	**0.89**	7.1	6.8	**1.04**
Ever Use Synthetic Marijuana	--	--	**--**	--	--	**--**	8.8	9.2	**0.95**	6.0	6.9	**0.87**
Ever Use Marijuana	40.1	39.9	**1.00**	39.5	40.7	**0.97**	38.7	38.6	**1.00**	36.9	35.6	**1.04**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 2: RI vs. Region Marijuana Use Past Month among High School Students (%), 2011-2017

	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2011	23.1	**26.3**	24.1	27.9	21.2	28.4	21.1	20.5	--	24.4
2013	23.4	**23.9**	26.0	24.8	21.3	24.4	21.0	21.4	--	25.7
2015	21.7	**23.6**	20.4	24.5	19.9	22.2	--	19.3	18.2	22.4
2017	19.8	**23.3**	20.4	24.1	18.8	23.1	--	18.4	17.7	23.5

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 3: RI vs. US Gender and Sexual Orientation Disparities in Marijuana Use Past Month (%), 2017

		Male	Female	Hetero-sexual	Gay or Lesbian	Bisexual	Gay, Lesbian, or Bisexual	Sexual Orientation Not Sure
2017	RI	22.6	23.4	22.4	29.3	30.9	30.6	22.0
	US	20.0	19.6	19.1	30.0	30.8	30.6	18.9
	RI/US Ratio	**1.13**	**1.19**	**1.17**	**0.98**	**1.00**	**1.00**	**1.16**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 4: RI vs. US Racial Disparities in Marijuana Use Past Month (%), 2017

		Asian*	Black	Hispanic	White	Multiple Races
2017	RI	--	26.7	22.6	22.3	38.2
	US	7.3	25.3	23.4	17.7	20.3
	RI/US Ratio	--	**1.06**	**0.97**	**1.26**	**1.88**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Sub-group data missing due to small sample size. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

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Table 5: RI vs. US Marijuana Indicators (%) by Age Group, 2013-2017

Age Group	12+			12-17			18-25			26+		
	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio
Marijuana Use Past Month												
2013-2014	12.75	7.96	**1.60**	10.69	7.22	**1.48**	28.90	19.32	**1.50**	9.92	6.11	**1.62**
2014-2015	13.02	8.34	**1.56**	10.19	7.20	**1.42**	28.89	19.70	**1.47**	10.39	6.55	**1.59**
2015-2016	15.21	8.60	**1.77**	10.50	6.75	**1.56**	32.00	20.30	**1.58**	12.65	6.88	**1.84**
2016-2017	15.75	9.23	**1.71**	9.49	6.46	**1.47**	31.86	21.45	**1.49**	13.51	7.56	**1.79**
Perceptions of Great Risk of Smoking Marijuana Once a Month*												
2013-2014	21.12	27.35	**0.77**	18.94	23.54	**0.80**	9.06	14.22	**0.64**	23.67	30.09	**0.79**
2015-2016	20.84	28.41	**0.73**	21.72	27.17	**0.80**	9.75	14.32	**0.68**	22.79	30.92	**0.74**
2016-2017	21.01	26.91	**0.78**	22.26	25.75	**0.86**	10.00	12.89	**0.78**	22.88	29.35	**0.78**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. The color scheme of RI/US Ratios for perceptions of great risk of smoking marijuana once a month are flipped to account for the fact that greater perception of risk is more desirable. *Data unavailable for 2014-2015. *Source: National Survey on Drug Use and Health (NSDUH)*

Table 6: RI vs. Region Marijuana Use Past Month (%) by Age Group, 2014-2017

	Age Group	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2014-2015	**12+**	8.34	**13.02**	9.59	11.68	13.66	12.06	7.01	9.56	7.73	14.74
	12-17	7.20	**10.19**	8.34	9.22	10.01	9.44	6.81	7.55	6.98	10.86
	18-25	19.70	**28.89**	24.99	27.39	29.72	29.12	18.96	22.69	18.97	34.95
	26+	6.55	**10.39**	7.25	9.21	11.84	9.65	5.23	7.54	6.02	11.61
2015-2016	**12+**	8.60	**15.21**	9.36	11.85	14.69	12.06	6.77	9.68	8.20	16.96
	12-17	6.75	**10.50**	7.95	8.68	9.70	8.06	5.72	7.28	6,25	9.44
	18-25	20.30	**32.00**	26.94	27.58	30.85	28.30	20.55	23.38	20.04	38.16
	26+	6.88	**12.65**	6.66	9.45	13.00	9.93	4.83	7.65	6.55	14.00
2016-2017	**12+**	9.23	**15.75**	10.59	13.38	15.81	12.90	7.15	9.47	8.23	18.64
	12-17	6.46	**9.49**	7.91	8.91	9.89	8.64	5.16	6.75	5.59	10.75
	18-25	21.45	**31.86**	30.35	30.27	34.38	28.93	22.34	23.35	21.38	38.80
	26+	7.56	**13.51**	7.69	10.94	13.89	10.86	5.12	7.50	6.48	15.91

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: National Survey on Drug Use and Health (NSDUH)*

Table 7: RI vs. Region Perceptions of Great Risk of Smoking Marijuana Once a Month (%) by Age Group, 2015-2017

	Age Group	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2015-2016	**12+**	28.41	**20.84**	23.76	22.14	19.65	18.78	32.12	28.51	24.78	18.23
	12-17	27.17	**21.72**	24.73	23.37	20.37	23.74	30.66	27.79	26.68	20.62
	18-25	14.32	**9.75**	11.29	11.56	7.86	7.79	14.16	14.43	10.88	7.70
	26+	30.92	**22.79**	25.69	23.86	21.19	20.01	35.00	30.97	26.78	19.85
2016-2017	**12+**	28.41	**21.01**	22.00	19.61	18.07	18.97	32.09	27.18	24.10	15.46
	12-17	27.17	**22.26**	22.39	20.33	19.33	22.78	29.71	26.53	25.24	17.10
	18-25	14.32	**10.00**	10.42	9.02	7.90	7.55	13.18	13.15	11.67	6.83
	26+	30.92	**22.88**	23.86	21.37	19.33	20.36	35.18	29.52	25.97	16.82

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: National Survey on Drug Use and Health (NSDUH)*

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Heroin & Opioids

Tables

Heroin & Opioid Indicator Performance

Heroin/Opioid Indicators		Data Source	Sustained Progress	Recent Progress	Comparable to the Nation	New Concern	Continuing Concern
Ever Use Heroin		*YRBSS*					
Heroin Use Past Year	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Nonmedical Use of Pain Relievers Past Year	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Perceptions of Great Risk from Trying Heroin Once or Twice	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Opioid Overdose Death Rate		*NVSS*					

Comparable to the Nation

Results from the NSDUH (Table 5) suggest that the prevalence of nonmedical use of pain relievers (past year) and perceptions of risk from heroin among all age groups 12+ years are comparable to the national average. Generally, 12-17 year olds perceive heroin use to be much less harmful than all other age groups.

Continuing Concern

Data from the YRBSS (Table 1) show that high school student reports of having ever used heroin remain higher than the national average, having previously been identified as a concern in 2015. RI high school student reports of having ever used heroin rank among the highest in the northeast, second only to New York (Table 2). When broken down by sexual orientation and racial identity, all demographic groups (except Asian and multiracial) exceed the national average, with males, sexual minorities, blacks and Hispanics most likely to report use (Tables 3,4). NSDUH data suggest consistent findings—with all age groups 12+ years in Rhode Island exceeding the nation for heroin use in the past year (Table 5). Yet, RI is comparable to other northeastern states (Table 6). Despite this ongoing concern, it is important to note that although this indicator meets the threshold for 15% increased prevalence in Rhode Island relative to the nation, the magnitude of the prevalence is very small and therefore the 15% increase may be negligible. Rhode Island age-adjusted opioid overdose deaths per 100,000 (Table 7). far exceed the national average. Rhode Island has had the highest rate of opioid overdose death in previous years, however since 2017, RI has been surpassed by Connecticut, Massachusetts, Maine, and New Hampshire (Table 7).

Table 1: RI vs. US Ever Use Heroin among High School Students (%), 2015-2017

% of Students (grades 9-12) Reporting:	2015	2017
RI	3.6	3.8
US	2.1	1.7
RI/US Ratio	1.71	2.24

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. No data available 2007-2013. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

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Table 2: RI vs. Region Ever Use Heroin among High School Students (%), 2015-2017

	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2015	2.1	**3.6**	2.2	1.7	--	2.4	--	4.8	2.0	2.3
2017	1.7	**3.8**	2.2	1.4	--	1.8	--	3.9	2.2	1.9

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 3: RI vs. US Gender and Sexual Orientation Disparities in Ever Use Heroin (%), 2017

		Male	Female	Hetero-sexual	Gay or Lesbian	Bisexual	Gay, Lesbian, or Bisexual	Sexual Orientation Not Sure
2017	RI	5.1	1.6	2.2	16.1	7.4	9.3	15.9
	US	2.4	0.9	1.1	5.1	3.1	3.5	7.7
	RI/US Ratio	**2.13**	**1.78**	**2.00**	**3.16**	**2.39**	**2.66**	**2.06**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 4: RI vs. US Racial Disparities in Ever Use Heroin (%), 2017

		Asian*	Black	Hispanic	White	Multiple Races
2017	RI	--	7.4	5.0	2.4	1.0
	US	1.5	2.2	1.8	1.1	3.1
	RI/US Ratio	--	**3.36**	**2.78**	**2.18**	**0.32**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Sub-group data missing due to small sample size. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 5: RI vs. US Heroin & Opioid Indicators (%) by Age Group, 2013-2017

Age Group	12+			12-17			18-25			26+		
	RI	**US**	**RI/US Ratio**	**RI**	**US**	**RI/US Ratio**	**RI**	**US**	**RI/US Ratio**	**RI**	**US**	**RI/US Ratio**
Heroin Use Past Year												
2013-2014	0.29	0.30	**0.97**	0.12	0.12	**1.00**	0.83	0.73	**1.14**	0.21	0.25	**0.84**
2014-2015	0.41	0.33	**1.24**	0.14	0.10	**1.40**	0.97	0.69	**1.41**	0.33	0.29	**1.14**
2015-2016	0.44	0.10	**4.40**	0.09	0.00	**9.00**	0.74	0.30	**2.47**	0.42	0.10	**4.20**
2016-2017	0.43	0.34	**1.26**	0.06	0.05	**1.20**	0.69	0.64	**1.08**	0.43	0.32	**1.34**
Nonmedical Use of Pain Relievers Past Year												
2013-2014	4.15	4.06	**1.02**	4.25	4.67	**0.91**	8.31	8.32	**1.00**	3.35	3.26	**1.03**
2014-2015	-	-	**-**	-	-	**-**	-	-	**-**	-	-	**-**
2015-2016	4.75	4.46	**1.07**	3.55	3.72	**0.95**	7.99	7.82	**1.02**	4.29	4.00	**1.07**
2016-2017	4.59	4.17	**1.10**	3.32	3.31	**1.00**	7.42	7.13	**1.04**	4.22	3.79	**1.11**
Perceptions of Great Risk from Trying Heroin Once or Twice												
2015-2016	85.35	85.44	**0.99**	64.05	65.41	**0.97**	82.91	82.80	**1.00**	88.01	88.23	**0.99**
2016-2017	84.99	86.00	**0.98**	63.88	65.92	**0.97**	81.28	82.76	**0.98**	87.84	88.85	**0.98**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. Nonmedical use of pain relievers is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs. Perception of harm from trying heroin data were not available prior to 2015-2016. *Source: National Survey on Drug Use and Health (NSDUH)*

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Table 6: RI vs. Region Heroin Use in the Past Year (%) by Age Group, 2014-2017

	Age Group	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2014-2015	12+	0.33	**0.41**	0.87	0.23	0.58	0.62	0.68	0.52	-	0.77
	12-17	0.10	**0.14**	0.10	0.08	0.17	0.22	0.16	0.11	-	0.18
	18-25	0.69	**0.97**	1.07	0.65	1.21	1.90	1.30	0.79	-	1.47
	26+	0.29	**0.33**	0.93	0.18	0.54	0.46	0.65	0.52	-	0.72
2015-2016	12+	0.10	**0.44**	0.71	0.36	0.48	0.87	0.51	0.42	0.44	0.56
	12-17	0.00	**0.09**	0.07	0.03	0.02	0.14	0.09	0.08	0.11	0.15
	18-25	0.30	**0.74**	1.21	0.66	1.15	1.90	0.92	0.63	0.84	1.19
	26+	0.10	**0.42**	0.70	0.35	0.43	0.79	0.50	0.42	0.41	0.49
2016-2017	12+	0.34	**0.43**	0.70	0.42	0.51	0.68	0.45	0.30	0.58	0.48
	12-17	0.05	**0.06**	0.06	0.03	0.05	0.09	0.05	0.04	0.08	0.08
	18-25	0.64	**0.69**	1.31	0.62	1.24	1.43	0.82	0.46	1.04	1.05
	26+	0.32	**0.43**	0.68	0.43	0.45	0.62	0.44	0.30	0.57	0.42

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: National Survey on Drug Use and Health (NSDUH)*

Table 7: RI vs. Region Opioid Overdose Death Rate per 100,000 (Age-Adjusted), 2013-2017

	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2013	7.9	**18.1**	12.3	13.3	9.9	11.8	7.6	8.3	7.8	11.6
2014	9.0	**19.8**	15.2	17.0	13.7	23.4	8.2	8.6	9.0	11.0
2015	10.4	**23.5**	19.2	23.3	19.3	31.3	9.8	10.8	11.2	13.4
2016	13.3	**26.7**	24.5	29.7	25.2	35.8	16.0	15.1	18.5	18.4
2017	14.9	**26.9**	27.7	28.2	29.9	34.0	22.0	16.1	21.2	20.0

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. Among the deaths with drug overdose as the underlying cause, the type of opioid involved is indicated by the following ICD-10 multiple cause-of-death codes: opioids (T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6); natural and semisynthetic opioids (T40.2); methadone (T40.3); synthetic opioids, other than methadone (T40.4); and heroin (T40.1). Age-adjusted death rates were calculated by applying age-specific death rates to the 2000 U.S. standard population age distribution. Deaths from illegally-made fentanyl cannot be distinguished from pharmaceutical fentanyl in the data source. For this reason, deaths from both legally prescribed and illegally produced fentanyl are included in these data. *Source: National Vital Statistics System (NVSS)*

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Other Drugs & Consequences

Tables

Other Drugs & Consequences Indicator Performance

Other Drugs Indicators		Data Source	Sustained Progress	Recent Progress	Comparable to the Nation	New Concern	Continuing Concern
Ever Use Cocaine		*YRBSS*					
Ever Use Ecstasy		*YRBSS*					
Ever Misuse Prescription Pain Medication		*YRBSS*					
Ever Misuse Steroids		*YRBSS*					
Illicit Drug Use Other than Marijuana Past Month	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Illicit Drug Use Past Month	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Needing but Not Receiving Treatment for Illicit Drug Use	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Needing but Not Receiving Treatment for Substance Use	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Cocaine Use Past Year	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Perceptions of Great Risk from Using Cocaine Once a Month	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Methamphetamine Use Past Year	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Malignant Neoplasms Death Rate		*NVSS*					
Circulatory System Disease Death Rate		*NVSS*					
Chronic Lower Respiratory Disease Death Rate		*NVSS*					
Alcoholic Liver Disease Death Rate		*NVSS*					
Drug-induced Death Rate		*NVSS*					
Alcohol-induced Death Rate		*NVSS*					

Recent Progress

According to a new indicator in 2017 YRBSS data, high school student reports of prescription pain medication misuse are significantly lower in Rhode Island than the nation, with prevalence of 9.8% versus 14.0%, respectively (Table 1). A new indicator in 2016-2017 NSDUH data suggest 18-25-year olds and those 26+ years in Rhode Island are less likely to use methamphetamines than their counterparts across the nation, with prevalence estimates below 0.5% (Table 10).

Comparable to the Nation

According to the YRBSS, Rhode Island high school student reports of ever using cocaine and ever using ecstasy have been comparable to US values since 2015 (Table 1). Needing but not receiving

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treatment for substance use among 26+ year olds in RI was a concern in 2015-2016 but is comparable to the nation according to most recent 2016-2017 NSDUH data (Table 5). Rhode Islanders aged 12+ years have comparable perceptions of harm from cocaine as their counterparts across the nation (Table 10). A new indicator in 2016-2017 NSDUH data suggest 12-17-year olds in Rhode Island are just as likely to use methamphetamines as others in the US (Table 10). Rhode Island mortality has been comparable to the nation since 2014 for death due to: malignant neoplasms, circulatory system disease, chronic lower respiratory disease, and alcoholic liver disease. Alcohol-induced mortality in RI has historically exceed that of the nation, but most recent data from 2017 suggest improvement relative to the nation—and are now comparable (Table 12).

New Concern

A new indicator to RI YRBS in 2015, having ever misused steroids, shows RI high school student reports exceed that of the nation in 2017, with 4.6% and 2.9%, respectively (Table 2). Few states have data for steroid misuse, but RI does exceed PA prevalence. All sexual orientation and racial groups of students were more likely to misuse steroids than national estimates except females and those who are multiracial (Tables 3,4) According to NSDUH, prevalence for past moth illicit drug use other than marijuana among 12-17 year olds continues to increase and has become a concern for Rhode Island relative to the nation in 2016-2017 (Table 5). Rhode Island also has the highest rate across all northeastern states (Tables 6, 7).

Continuing Concern

According to NSDUH, prevalence for past month illicit drug use other than marijuana among 18-25 and 26+ year olds has remained a concern for Rhode Island relative to the nation in 2015-2016 and 2016-2017 (Table 5). For 18-25-year olds in 2016-2017, illicit drug use other than marijuana in the past month was comparable to other northeastern states. However, among those 26+ years, RI has the highest rate in the northeast (Table 6). Similarly, NSDUH data suggest all age groups 12+ years in Rhode Island continue to exceed the nation for any illicit drug use in the past month (Table 5), with those 12-17 years old having the highest rate in the northeast in 2016-2017, those 18-25 years comparable to other northeastern states, and those 26+ years surpassed only by Vermont. Rhode Islanders across all age groups have higher rates of needing but not receiving treatment for illicit drug use compared to the nation since 2015-2016; the same is true among 12-17 and 18-25-year olds needing but not receiving treatment for substance use (Table 5). RI is second only to Vermont for 12-17-year olds needing but not receiving treatment for substance use, while rates for 18-25 year olds are comparable to other northeastern states. Past year cocaine use based upon NSDUH data (Table 10) continues to be a concern among all age groups relative to the nation since 2014-2015, with a prevalence of 7.68% among RI 18-25-year olds in 2016-2017. Rates of past year cocaine use for all age groups 12+ years are comparable to other northeastern states (Table 11). Drug-induced mortality in RI has consistently increased and exceeded that of the nation since 2014 (Table 13). Drug-induced mortality in RI is highest among 35-44 year olds and exceeds the national rate for all age groups except those 55-64 years old. Drug-induced mortality for 45-54-year olds in RI is among the highest in the northeast, after Pennsylvania and Massachusetts (Table 13). These rates were higher than the nation's for all racial/ethnic and gender groups (Tables 14, 15).

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Table 1: RI vs. US Other Drug Use among High School Students (%), 2013-2017

% of Students (grades 9-12) Reporting:	2013			2015			2017		
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US
Ever Use Cocaine	4.5	5.5	**0.82**	4.8	5.2	**0.92**	4.4	4.8	**0.92**
Ever Use Ecstasy	--	--	**--**	5.1	5.0	**1.02**	3.9	4.0	**0.98**
Ever Misuse Prescription Pain Medication	--	--	**--**	--	--	**--**	9.8	14.0	**0.70**
Ever Misuse Steroids	--	3.2	**--**	3.8	3.5	**1.09**	4.6	2.9	**1.59**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. Prescription pain med misuse was defined as ever taking prescription pain medications, including codeine, Vicodin, Oxycontin, hydrocodone or Percocet, without a doctor's prescription or differently than how a doctor told them to use it. Steroid misuse was defined as ever taking steroids without a doctor's prescription including pills or shots. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 2: RI vs. Region Ever Misuse Steroids among High School Students (%), 2015-2017

	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2015	3.5	**3.8**	--	--	--	--	--	--	2.5	--
2017	2.9	**4.6**	--	--	--	--	--	--	2.7	--

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 3: RI vs. US Gender and Sexual Orientation Disparities in Ever Misuse Steroids (%), 2017

		Male	Female	Hetero-sexual	Gay or Lesbian	Bisexual	Gay, Lesbian, or Bisexual	Sexual Orientation Not Sure
2017	RI	5.5	2.7	3.2	16.0	7.1	9.1	13.2
	US	3.3	2.4	2.3	8.2	5.5	6.1	6.5
	RI/US Ratio	**1.67**	**1.13**	**1.30**	**1.95**	**1.29**	**1.49**	**2.03**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 4: RI vs. US Racial Disparities in Ever Misuse Steroids (%), 2017

		Asian*	Black	Hispanic	White	Multiple Races
2017	RI	--	8.7	5.1	3.4	0.5
	US	2.7	3.6	3.5	2.2	2.9
	RI/US Ratio	--	**2.42**	**1.46**	**1.55**	**0.17**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Sub-group data missing due to small sample size. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

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Table 5: RI vs. US Other Drug Indicators (%) by Age Group, 2013-2017

Age Group	12+			12-17			18-25			26+		
	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio
Illicit Drug Use Other than Marijuana Past Month												
2015-2016	4.23	3.42	**1.24**	2.64	2.71	**0.97**	9.63	7.32	**1.32**	3.41	2.86	**1.19**
2016-2017	4.31	3.38	**1.28**	2.84	2.43	**1.17**	8.90	7.07	**1.26**	3.64	2.88	**1.26**
Any Illicit Drug Use Past Month												
2013-2014	14.53	9.77	**1.48**	12.14	9.11	**1.33**	31.02	21.75	**1.42**	11.67	7.81	**1.49**
2014-2015	--	--	**--**	--	--	**--**	--	--	**--**	--	--	**--**
2015-2016	16.57	10.36	**1.59**	12.47	8.34	**1.50**	33.63	22.75	**1.48**	13.90	8.54	**1.63**
2016-2017	17.45	10.90	**1.60**	11.81	7.88	**1.50**	33.07	23.69	**1.40**	15.24	9.18	**1.66**
Needing but Not Receiving Treatment for Illicit Drug Use												
2013-2014	2.86	2.35	**1.22**	3.69	3.29	**1.12**	7.18	6.40	**1.12**	1.96	1.55	**1.26**
2014-2015	--	--	**--**	--	--	**--**	--	--	**--**	--	--	**--**
2015-2016	3.68	2.53	**1.45**	4.61	3.14	**1.47**	8.76	6.62	**1.32**	2.66	1.78	**1.49**
2016-2017	3.07	2.45	**1.25**	3.64	2.92	**1.25**	7.70	6.58	**1.17**	2.18	1.72	**1.27**
Needing but Not Receiving Treatment for Substance Use												
2015-2016	8.53	7.08	**1.20**	5.68	4.38	**1.30**	16.48	14.34	**1.15**	7.39	6.20	**1.19**
2016-2017	7.96	6.82	**1.17**	4.61	3.89	**1.19**	16.40	14.07	**1.17**	6.79	5.98	**1.14**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, Hallucinogens, inhalants, or methamphetamine. Illicit Drug Use Other Than Marijuana includes the misuse of prescription psychotherapeutics or the use of cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Respondents were classified as needing substance use treatment if they met the criteria for illicit drug or alcohol use disorder as defined in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) or received treatment for illicit drug or alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center). Needing But Not Receiving Substance Use Treatment refers to respondents who are classified as needing illicit drug or alcohol treatment, but who did not receive illicit drug or alcohol treatment at a specialty facility. *Source: National Survey on Drug Use and Health (NSDUH)*

Table 6: RI vs. Region Illicit Drug Use Other than Marijuana in the Past Month (%) by Age Group 2015-17

	Age Group	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2015-2016	**12+**	3.42	**4.23**	3.68	3.75	2.75	3.88	2.91	3.42	3.59	4.68
	12-17	2.71	**2.64**	2.65	2.25	2.61	2.28	2.14	2.22	2.20	2.15
	18-25	7.32	**9.63**	9.27	8.44	6.32	11.40	7.48	6.91	7.61	13.92
	26+	2.86	**3.41**	2.89	3.10	2.28	2.86	2.32	2.96	3.11	3.32
2016-2017	**12+**	3.38	**4.31**	3.73	4.26	2.97	3.66	2.74	3.30	3.36	4.71
	12-17	2.43	**2.84**	2.27	2.29	2.14	2.63	1.92	1.91	2.02	2.40
	18-25	7.07	**8.90**	9.26	9.19	7.40	10.37	6.68	6.89	7.79	14.55
	26+	2.88	**3.64**	3.00	3.62	2.45	2.73	2.25	2.87	2.81	3.23

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. Illicit Drug Use Other Than Marijuana includes the misuse of prescription psychotherapeutics or the use of cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. *Source: National Survey on Drug Use and Health (NSDUH)*

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Table 7: RI vs. Region Any Illicit Drug Past Month (%) by Age Group, 2013-2017

	Age Group	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2013-2014	12+	9.77	14.53	9.91	13.23	13.50	12.60	7.96	10.42	9.20	14.46
	12-17	9.11	12.14	9.53	9.69	10.82	11.10	7.95	9.41	8.88	12.73
	18-25	21.75	31.02	24.25	31.09	29.11	32.01	19.19	22.04	22.24	32.30
	26+	7.81	11.67	7.65	10.49	11.60	9.74	6.27	8.53	7.11	11.55
2015-2016	12+	10.36	16.57	10.95	14.01	14.86	13.43	8.13	11.16	10.51	18.20
	12-17	8.34	12.47	9.48	10.32	10.96	8.98	6.90	8.43	7.60	10.90
	18-25	22.75	33.63	28.86	30.10	31.20	32.23	23.31	25.14	22.97	40.00
	26+	8.54	13.90	8.21	11.61	13.03	10.94	6.01	9.12	8.87	15.12
2016-2017	12+	10.90	17.45	12.33	16.00	16.35	14.28	8.45	11.06	10.15	19.41
	12-17	7.88	11.81	9.64	10.90	10.67	9.87	6.37	7.86	6.73	11.80
	18-25	23.69	33.07	32.68	33.41	36.10	32.43	25.09	25.04	23.74	40.32
	26+	9.18	15.24	9.34	13.55	14.25	11.93	6.22	9.12	8.42	16.53

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. No data available for 2014-2015. *Source: National Survey on Drug Use and Health (NSDUH)*

Table 8: RI vs. Region Needing but Not Receiving Treatment for Illicit Drug Use (%) by Age Group 2013-17

	Age Group	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2013-2014	12+	2.35	2.86	2.47	2.71	2.26	2.39	2.13	2.52	2.34	2.66
	12-17	3.29	3.69	3.13	3.43	2.89	3.57	2.93	3.03	2.78	3.14
	18-25	6.40	7.18	7.63	7.50	7.24	7.23	6.46	6.24	6.40	8.02
	26+	1.55	1.96	1.56	1.79	1.50	1.50	1.39	1.82	1.63	1.68
2015-2016	12+	2.53	3.68	3.26	3.15	2.45	2.87	1.84	2.49	2.41	3.28
	12-17	3.14	4.61	3.70	3.00	2.93	3.05	2.41	2.76	2.23	3.23
	18-25	6.62	8.76	8.55	7.54	6.3	8.17	5.59	6.78	6.09	9.72
	26+	1.78	2.66	2.35	2.41	1.84	2.02	1.22	1.75	1.85	2.15
2016-2017	12+	2.45	3.07	3.11	3.03	2.70	2.66	1.85	2.52	2.23	3.30
	12-17	2.92	3.64	3.25	2.90	2.90	2.92	2.40	2.80	2.14	3.25
	18-25	6.58	7.70	8.71	7.47	7.35	8.51	5.52	7.02	5.47	10.33
	26+	1.72	2.18	2.18	2.28	2.06	1.73	1.25	1.76	1.47	2.09

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. No data available for 2014-2015. *Source: National Survey on Drug Use and Health (NSDUH)*

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Table 9: RI vs. Region Needing but Not Receiving Treatment for Substance Abuse (%) by Age 2015-2017

	Age Group	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2015-2016	12+	7.08	8.53	8.47	8.78	7.18	7.63	5.82	7.13	6.86	8.31
	12-17	4.38	5.68	5.17	4.61	4.85	4.35	3.75	4.10	3.47	4.93
	18-25	14.34	16.48	16.77	18.04	15.12	16.64	14.25	14.75	15.63	20.66
	26+	6.20	7.39	7.51	7.62	6.34	6.56	4.80	6.18	5.85	6.49
2016-2017	12+	6.82	7.96	7.51	8.75	7.69	7.80	7.80	7.05	6.12	8.75
	12-17	3.89	4.61	4.54	4.26	4.64	4.17	4.17	3.73	2.97	4.87
	18-25	14.07	16.40	16.35	19.02	15.55	18.13	18.13	14.19	13.58	21.49
	26+	5.98	6.79	6.42	7.46	6.93	6.58	6.58	6.24	5.30	6.91

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. Needing But Not Receiving Substance Use Treatment refers to respondents who are classified as needing illicit drug or alcohol treatment, but who did not receive illicit drug or alcohol treatment at a specialty facility. No data available prior to 2015-2016. *Source: National Survey on Drug Use and Health (NSDUH)*

Table 10: RI vs. US Cocaine and Methamphetamine Indicators (%) by Age Group, 2013-2017

Age Group	12+			12-17			18-25			26+		
	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio
Cocaine Use Past Year												
2013-2014	2.00	1.66	1.20	0.57	0.60	0.95	5.85	4.51	1.30	1.42	1.30	1.09
2014-2015	2.52	1.76	1.43	0.74	0.64	1.16	7.64	4.98	1.53	1.77	1.35	1.31
2015-2016	2.79	0.70	3.98	0.84	0.20	4.20	8.90	1.70	5.24	1.88	0.60	3.13
2016-2017	2.66	2.03	1.31	0.70	0.53	1.32	7.68	5.88	1.31	1.97	1.59	1.24
Perceptions of Great Risk from Using Cocaine Once a Month												
2015-2016	71.89	68.96	1.04	56.54	57.65	0.98	65.07	61.92	1.05	74.84	71.42	1.04
2016-2017	71.55	67.42	1.06	56.01	56.01	1.00	63.91	59.38	1.07	74.62	70.15	1.06
Methamphetamine Use Past Year												
2016-2017	0.39	0.56	0.70	0.15	0.16	0.94	0.44	0.93	0.47	0.40	0.55	0.73

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: National Survey on Drug Use and Health (NSDUH)*

Table 11: RI vs. Region Cocaine Use Past Year (%), by Age Group, 2014-2017

	Age Group	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2014-2015	12+	1.76	2.52	2.43	2.45	1.79	3.07	1.72	2.54	1.52	2.67
	12-17	0.64	0.74	0.67	0.71	0.65	0.83	0.60	0.73	0.54	0.81
	18-25	4.98	7.64	7.60	7.28	6.41	10.54	4.55	6.29	4.71	9.33
	26+	1.35	1.77	1.80	1.79	1.27	2.13	1.42	2.10	1.24	1.70
2015-2016	12+	0.70	2.79	2.48	2.80	1.82	2.78	1.93	2.37	1.87	3.02
	12-17	0.20	0.84	0.62	0.73	0.86	1.13	0.55	0.45	0.56	1.14
	18-25	1.70	8.90	9.07	9.07	6.44	10.84	6.63	5.77	5.22	10.83
	26+	0.60	1.88	1.62	1.94	1.30	1.69	1.38	2.01	1.48	1.84
2016-2017	12+	2.03	2.66	2.74	3.05	1.86	2.20	1.87	2.46	1.98	3.50
	12-17	0.53	0.70	0.60	0.64	0.70	0.89	0.49	0.44	0.54	0.93
	18-25	5.88	7.68	8.36	9.35	6.62	8.81	6.48	5.79	5.57	12.24
	26+	1.59	1.97	2.08	2.22	1.33	1.32	1.34	2.13	1.58	2.23

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: National Survey on Drug Use and Health (NSDUH)*

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Table 12: RI vs. US Substance Related Age-Adjusted Death Rates per 100,000, 2014-2017

	2014			2015			2016			2017		
	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio
Malignant Neoplasms	170.8	165.7	**1.03**	166.7	162.9	**1.02**	162.0	160.0	**1.01**	158.5	156.6	**1.01**
Circulatory System Disease	200.8	219.9	**0.91**	202.3	222.7	**0.91**	192.2	219.4	**0.88**	199.7	219.4	**0.91**
Chronic Lower Respiratory Disease	36.0	40.5	**0.89**	36.9	41.6	**0.89**	31.3	40.6	**0.77**	36.2	40.9	**0.89**
Alcoholic Liver Disease	5.2	5.4	**0.96**	6.0	5.7	**1.05**	6.5	5.9	**1.10**	5.1	5.9	**0.86**
Drug-induced	23.9	15.5	**1.54**	28.9	17.2	**1.68**	31.1	20.8	**1.50**	31.2	22.8	**1.37**
Alcohol-induced	10.7	8.5	**1.26**	11.9	9.1	**1.31**	12.1	9.5	**1.27**	9.6	9.6	**1.00**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below than the US average. Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018. Data are from the Multiple Cause of Death Files, 1999-2017, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html on Nov 15, 2019 1:42:28 PM Alcoholic liver disease deaths include ICD-10 codes K70.0 (Alcoholic fatty liver); K70.1 (Alcoholic hepatitis); K70.2 (Alcoholic fibrosis and sclerosis of liver); K70.3 (Alcoholic cirrhosis of liver); K70.4 (Alcoholic hepatic failure); K70.9 (Alcoholic liver disease, unspecified).
Sources: National Vital Statistics System (NVSS)

Table 13: RI vs. Region Drug-induced Deaths per 100,000 by Age Group, 2015-2017

	Age Group	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2015	**15-24**	10.0	**15.6**	13.9	18.4	--	23.4	13.9	10.5	18.4	--
	25-34	28.0	**57.2**	40.8	59.2	49.2	87.1	34.0	24.4	55.6	39.1
	35-44	29.6	**41.9**	37.8	51.7	42.6	73.6	28.5	23.6	48.3	31.1
	45-54	31.9	**52.1**	42.0	44.8	34.7	43.3	27.3	27.4	44.5	34.7
	55-64	23.3	**47.0**	29.6	22.2	18.7	20.3	16.6	20.3	26.7	--
2016	**15-24**	12.8	**15.1**	13.9	19.5	17.8	32.8	19.0	14.1	26.0	--
	25-34	35.9	**57.3**	54.1	72.8	62.4	99.6	52.6	35.0	80.4	57.8
	35-44	36.6	**49.6**	50.4	70.3	63.0	77.5	37.6	31.3	71.9	53.2
	45-54	36.5	**69.5**	50.4	53.6	46.1	47.3	39.3	33.0	62.5	30.1
	55-64	27.7	**34.7**	33.1	37.3	21.4	23.3	24.4	24.7	36.0	--
2017	**15-24**	13.0	**--**	18.7	15.7	15.4	24.5	22.1	11.8	28.6	--
	25-34	39.8	**52.4**	63.7	67.4	82.1	95.5	62.1	35.8	95.6	52.1
	35-44	40.6	**67.2**	62.7	64.9	72.7	68.4	51.8	34.9	89.3	54.6
	45-54	39.8	**57.9**	49.2	58.4	54.2	55.1	51.6	37.0	65.1	28.7
	55-64	30.0	**31.6**	33.5	36.3	25.5	26.3	33.9	26.5	43.1	--

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below than the US average. *Sources: National Vital Statistics System (NVSS)*

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Table 14: RI vs. US Racial Disparities in Age-Adjusted Drug-induced Deaths per 100,000, 2015-2017

		American Indian or Alaska Native*	Asian or Pacific Islander*	Black*	Hispanic	White
2015	RI	--	--	--	24.6	31.7
	US	22.0	3.0	13.2	8.2	21.8
	RI/US Ratio	--	--	--	**3.00**	**1.45**
2016	RI	--	--	--	16.7	37.0
	US	25.6	3.5	18.3	10.1	25.9
	RI/US Ratio	--	--	--	**1.65**	**1.43**
2017	RI	--	--	--	20.7	35.8
	US	27.9	3.7	21.9	11.2	28.8
	RI/US Ratio	--	--	--	**1.85**	**1.24**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below than the US average. *RI data for American Indian or Alaska Native, Asian or Pacific Islander, and Black suppressed due to small sample size. *Sources: National Vital Statistics System (NVSS)*

Table 15: RI vs. US Gender Disparities in Age-Adjusted Drug-induced Deaths per 100,000, 2015-2017

		Male	Female
2015	RI	41.7	16.6
	US	21.9	12.5
	RI/US Ratio	**1.90**	**1.33**
2016	RI	44.9	17.9
	US	27.6	14.2
	RI/US Ratio	**1.63**	**1.26**
2017	RI	41.5	21.0
	US	30.5	15.2
	RI/US Ratio	**1.36**	**1.38**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below than the US average. *Sources: National Vital Statistics System (NVSS)*

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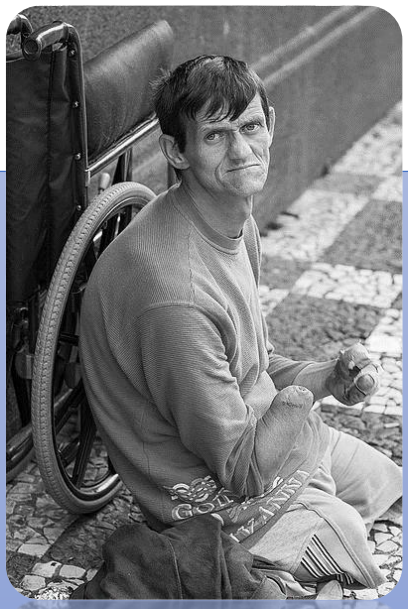
Mental Health

Tables



Mental Health Indicator Performance

Mental Health Indicators		Data Source	Sustained Progress	Recent Progress	Comparable to the Nation	New Concern	Continuing Concern
Felt Sad or Hopeless Past Year		*YRBSS*					
Considered Suicide Past Year		*YRBSS*					
Planned Suicide Past Year		*YRBSS*					
Attempted Suicide Past Year		*YRBSS*					
Injurious Attempted Suicide Past Year		*YRBSS*					
Serious Mental Illness Past Year	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Any Mental Illness Past Year	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Had at least one Major Depressive Episode Past Year	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Received Mental Health Services Past Year	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Had Serious Thoughts of Suicide Past Year	Age 12-17	*NSDUH*					
	Age 18-25						
	Age 26+						
Ever Told You Have Depression		*BRFSS*					
Frequent Mental Distress		*BRFSS*					
Mental and Behavioral Disorder Death Rate		*NVSS*					

Comparable to the Nation

Rhode Island high school students, according to the YRBSS, have consistently been similar to high school students across the nation for rates of feeling sad or hopeless in the past year, considering suicide in the past year, and planning suicide in the past year (Table 1). Similarly according to NSDUH data, all age groups 12+ years in Rhode Island have comparable mental health experience to the nation overall for past year serious mental illness, having any mental illness in the past year, having had at least one major depressive episode in the past year, and having serious thoughts of suicide in the past year (Table 5). Adults aged 18+ years in RI, according to the BRFSS, also have comparable rates to the nation for having ever been told they have depression (Table 7).

Continuing Concern

As identified by the YRBSS, high school student reports of attempted suicide and injurious attempted suicide continue to be more prevalent in Rhode Island than the nation (Table 1). Compared to the region (Table 2), Rhode Island has the highest prevalence of high school student attempted suicide (10.5%) in 2017 and among the highest for prevalence of injurious attempted suicide (3.8%). When examining by gender, sexual orientation and racial disparities (Tables 3,4), rates of attempted suicide among Rhode Island high school students are higher than the nation for males, and all sexual orientation groups. Racial groups in Rhode Island who fare worse than the nation for attempted suicide are Hispanic, white, and multiracial high school students. The

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same applies for injurious attempted suicide, where all subgroups in Rhode Island, regardless of gender, race/ethnicity or sexual orientation, exceed the national averages (Tables 3,4). Rates of receiving mental health services in the past year are increasing and continue to be higher in Rhode Island relative to the nation for those aged 18+ years, as identified by NSDUH (Table 5). Rhode Island rates of mental health service receipt are among the highest in the region (Table 6). Frequent mental distress, defined as poor mental health for 14 or more days in the past 30 days according to the BRFSS, is significantly higher among RI adults than the national average in 2017 and 2018. In particular, 18-44 and 45-64-year olds have more frequent mental distress than others nationally, as do males, blacks, Hispanics, those with less than a high school education and those with some college (Tables 9-11). Mental and behavioral health death rates in RI have exceeded the nation by about 50% for the past few years (Table 12). However, further sub-group examination is not feasible due to small sample size.

Table 1: RI vs. US Mental Health Indicators among High School Students (%), 2011-2017

% of Students (grades 9-12) Reporting:	2011			2013			2015			2017		
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US
Felt Sad Or Hopeless Past Year	24.6	28.5	**0.86**	25.8	29.9	**0.86**	26.4	29.9	**0.88**	29.4	31.5	**0.93**
Considered Suicide Past Year	12.3	17.0	**0.72**	13.9	17.0	**0.82**	14.1	17.7	**0.80**	15.9	17.2	**0.92**
Planned Suicide Past Year	10.7	12.8	**0.83**	9.9	13.6	**0.72**	12.1	14.6	**0.83**	13.6	13.6	**1.00**
Attempted Suicide Past Year	8.7	7.8	**1.11**	14.3	8.0	**1.79**	10.5	8.6	**1.22**	10.5	7.4	**1.42**
Injurious Attempted Suicide Past Year	3.9	2.4	**1.62**	--	2.7	**--**	4.1	2.8	**1.46**	3.8	2.4	**1.58**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 2: RI vs. Region Suicide Indicators among High School Students (%), 2011-2017

	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
Attempted Suicide Past Year										
2011	7.8	**8.7**	6.7	6.8	7.6	6.1	6.0	7.1	--	3.6
2013	8.0	**14.3**	8.1	5.5	8.1	6.7	9.9	7.1	--	5.6
2015	8.6	**10.5**	7.9	7.0	9.9	6.8	--	9.9	7.5	5.9
2017	7.4	**10.5**	8.1	5.4	7.4	5.9	--	10.1	7.4	5.4
Injurious Attempted Suicide Past Year										
2011	2.4	**3.9**	--	2.3	--	2.4	2.1	2.6	--	--
2013	2.7	**--**	--	1.9	--	2.5	--	2.4	--	2.0
2015	2.8	**4.1**	--	2.8	--	2.5	--	4.4	2.6	--
2017	2.4	**3.8**	--	1.9	--	2.0	--	4.1	3.0	--

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

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Table 3: RI vs. US Gender and Sexual Orientation Disparities in Suicide Indicators (%), 2017

		Male	Female	Hetero-sexual	Gay or Lesbian	Bisexual	Gay, Lesbian, or Bisexual	Sexual Orientation Not Sure
	Attempted Suicide Past Year							
2017	RI	9.4	10.3	7.0	34.6	25.8	27.8	15.0
	US	5.1	9.3	5.4	18.6	24.2	23.0	14.3
	RI/US Ratio	**1.84**	**1.11**	**1.30**	**1.90**	**1.10**	**1.20**	**1.70**
	Injurious Attempted Suicide Past Year							
2017	RI	3.5	3.4	2.5	10.1	11.1	10.9	7.6
	US	1.5	3.1	1.7	9.6	6.9	7.5	5.6
	RI/US Ratio	**2.33**	**1.10**	**1.47**	**1.05**	**1.61**	**1.45**	**1.36**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 4: RI vs. US Racial Disparities in Suicide Indicators (%), 2017

		Asian*	Black	Hispanic	White	Multiple Races
	Attempted Suicide Past Year					
2017	RI	--	10.2	15.0	7.6	12.9
	US	5.7	9.8	8.2	6.1	10.8
	RI/US Ratio	--	**1.04**	**1.83**	**1.25**	**1.19**
	Injurious Attempted Suicide Past Year					
2017	RI	--	5.3	5.2	2.7	4.6
	US	2.7	3.4	2.8	1.9	3.5
	RI/US Ratio	--	**1.56**	**1.86**	**1.42**	**1.31**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Sub-group data missing due to small sample size.
Source: Youth Risk Behavior Surveillance System (YRBSS)

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Table 5: RI vs. US Mental Health Indicators (%) by Age Group, 2013-2017

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**	**RI/US Ratio**
2013-2014	4.77	4.15	**1.15**	4.79	4.52	**1.06**	4.76	4.09	**1.16**
2014-2015	4.51	4.05	**1.11**	5.13	4.92	**1.04**	4.39	3.91	**1.12**
2015-2016	4.24	4.13	**1.03**	5.71	5.46	**1.05**	3.97	3.91	**1.02**
2016-2017	4.52	4.38	**1.03**	7.07	6.68	**1.06**	4.06	4.01	**1.01**
Any Mental Illness in the Past Year									
2013-2014	21.60	18.29	**1.18**	21.09	19.75	**1.07**	21.70	18.05	**1.20**
2014-2015	20.50	18.01	**1.14**	22.01	20.89	**1.05**	20.22	17.52	**1.15**
2015-2016	19.23	18.07	**1.06**	23.60	21.89	**1.08**	18.43	17.44	**1.06**
2016-2017	19.59	18.57	**1.05**	24.76	23.93	**1.03**	18.67	17.69	**1.06**
Had at Least One Major Depressive Episode in the Past Year									
2013-2014	7.68	6.63	**1.16**	9.89	9.00	**1.10**	7.27	6.22	**1.17**
2014-2015	7.08	6.64	**1.07**	9.81	9.79	**1.00**	6.57	6.11	**1.08**
2015-2016	7.23	6.70	**1.08**	11.17	12.63	**0.88**	6.52	6.06	**1.08**
2016-2017	7.41	6.89	**1.08**	13.30	13.01	**1.02**	6.57	6.07	**1.08**
Received Mental Health Services in the Past Year									
2015-2016	18.96	14.28	**1.33**	16.54	12.28	**1.35**	19.40	14.61	**1.33**
2016-2017	19.73	14.60	**1.35**	18.57	13.90	**1.34**	19.94	14.72	**1.35**
Had Serious Thoughts of Suicide in the Past Year									
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**	3.62	3.34	**1.08**
2015-2016	4.49	4.04	**1.11**	9.55	8.57	**1.11**	3.57	3.30	**1.08**
2016-2017	4.78	4.19	**1.14**	10.62	9.64	**1.10**	3.73	3.31	**1.13**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. Mental Health Services are defined as having received inpatient treatment/counseling or outpatient treatment/counseling or having used prescription medication for problems with emotions, nerves, or mental health. Respondents were not to include treatment for drug or alcohol use.
Source: National Survey on Drug Use and Health (NSDUH)

Table 6: RI vs. Region Received Mental Health Services in the Past Year (%) by Age Group, 2015-2017

	Age Group	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2015-2016	**18+**	14.28	**18.96**	17.05	18.86	19.37	20.72	12.67	14.47	16.35	20.39
	18-25	12.28	**16.54**	15.28	16.59	17.37	20.55	11.82	12.10	13.06	22.34
	26+	14.61	**19.40**	17.33	19.25	19.64	20.75	12.80	14.86	16.86	20.05
2016-2017	**18+**	14.60	**19.73**	16.61	19.69	19.16	19.12	12.45	14.16	16.39	21.38
	18-25	13.90	**18.57**	18.42	17.31	19.18	19.88	12.09	13.83	15.59	23.04
	26+	14.72	**19.94**	16.31	20.11	19.15	19.00	12.51	14.21	16.51	21.09

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: National Survey on Drug Use and Health (NSDUH)*

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Table 7: RI vs. US Adult Depression Indicators (%), 2011-2018

	2011	2012	2013	2014	2015	2016	2017	2018
Ever Told You Have Depression								
RI	22.00	20.30	22.20	20.60	21.30	22.30	23.10	20.80
US	17.50	17.60	18.70	18.70	18.90	17.30	20.00	19.60
RI/US Ratio	**1.26**	**1.15**	**1.19**	**1.10**	**1.13**	**1.29**	**1.16**	**1.06**
Frequent Mental Distress								
RI	--	13.3	12.8	11.3	11.0	12.4	13.5	14.6
US	--	11.7	11.7	11.3	11.0	11.2	11.7	12.0
RI/US Ratio	--	**1.14**	**1.09**	**1.00**	**1.00**	**1.11**	**1.15**	**1.22**

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. Frequent Mental Distress is defined by those reporting their mental health was not good 14 or more days in the past 30 days. *Source: Behavioral Risk Factor Surveillance Survey (BRFSS)*

Table 8: RI vs. US Age Disparities in Frequent Mental Distress (%), 2018

		18-44 Years	45-64 Years	65+ Years
2018	RI	18.0	14.7	7.2
	US	14.1	12.8	7.9
	RI/US Ratio	**1.28**	**1.15**	**0.91**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below than the US average. RI data for American Indian or Alaska Native, Asian, Hawaiian/Pacific Islander, and Other Race suppressed due to small sample size. Frequent Mental Distress is defined by those reporting their mental health was not good 14 or more days in the past 30 days. *Source: Behavioral Risk Factor Surveillance Survey (BRFSS)*

Table 9: RI vs. US Gender Disparities in Frequent Mental Distress (%), 2018

		Male	Female
2018	RI	13.4	15.5
	US	10.4	14.3
	RI/US Ratio	**1.29**	**1.08**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below than the US average. RI data for American Indian or Alaska Native, Asian, Hawaiian/Pacific Islander, and Other Race suppressed due to small sample size. Frequent Mental Distress is defined by those reporting their mental health was not good 14 or more days in the past 30 days. *Source: Behavioral Risk Factor Surveillance Survey (BRFSS)*

Table 10: RI vs. US Racial/Ethnic Disparities in Frequent Mental Distress (%), 2018

		American Indian or Alaska Native	Asian	Black	Hawaiian/ Pacific Islander	Hispanic	Multi-racial	Other Race	White
2018	RI	--	--	16.4	--	18.8	20.4	--	14.1
	US	18.7	7.7	13.2	12.6	11.6	20.8	13.5	12.5
	RI/US Ratio	--	--	**1.24**	--	**1.49**	**0.98**	--	**1.13**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below than the US average. RI data for American Indian or Alaska Native, Asian, Hawaiian/Pacific Islander, and Other Race suppressed due to small sample size. Frequent Mental Distress is defined by those reporting their mental health was not good 14 or more days in the past 30 days. *Source: Behavioral Risk Factor Surveillance Survey (BRFSS)*

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Table 11: RI vs. US Education Disparities in Frequent Mental Distress (%), 2018

		Less than High School	High School Grad	Some College	College Grad
2018	RI	26.6	14.2	15.4	7.0
	US	17.2	13.2	12.8	7.1
	RI/US Ratio	**1.55**	**1.08**	**1.20**	**0.99**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below than the US average. RI data for American Indian or Alaska Native, Asian, Hawaiian/Pacific Islander, and Other Race suppressed due to small sample size. Frequent Mental Distress is defined by those reporting their mental health was not good 14 or more days in the past 30 days.
Source: Behavioral Risk Factor Surveillance Survey (BRFSS)

Table 12: RI vs. US Mental Health Related Age-Adjusted Death Rates per 100,000, 2014-2017

	2014			2015			2016			2017		
	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio
Mental and Behavioral Disorder	54.4	40.9	**1.33**	55.3	36.3	**1.52**	51.3	34.6	**1.48**	52.7	34.7	**1.52**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below than the US average. Mental and behavioral disorder deaths categorized by ICD-10 codes F01-F99. Sub-group analyses are unavailable due to small sample size. *Sources: National Vital Statistics System (NVSS)*

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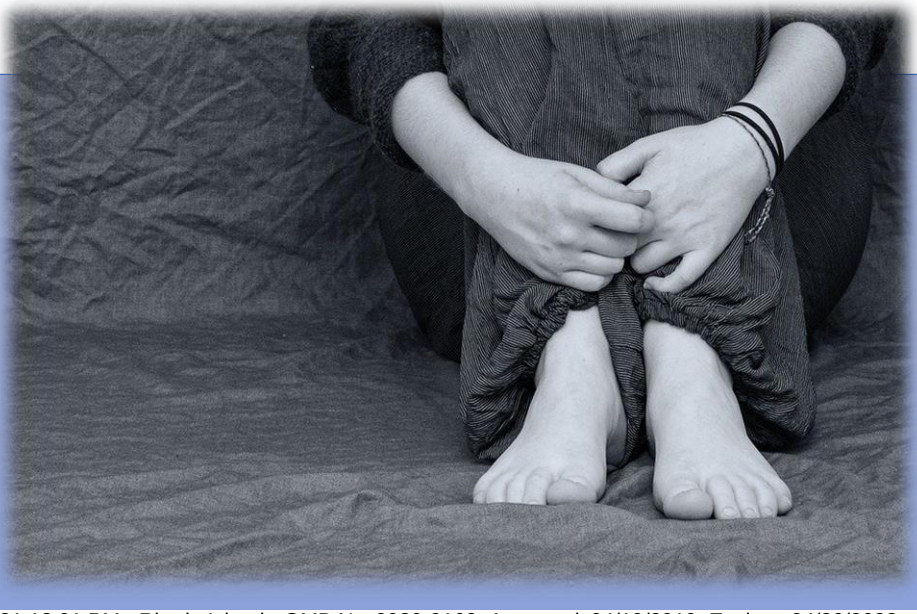
Injury & Violence

Tables



Injury & Violence Indicator Performance

Injury/Violence Indicators	Data Source	Sustained Progress	Recent Progress	Comparable to the Nation	New Concern	Continuing Concern
Texting and Driving	*YRBSS*					
Rarely or Never Wore Seat Belt	*YRBSS*					
Carried Weapon at School Past Month	*YRBSS*					
Physical Fight on School Property Past Year	*YRBSS*					
Missed School Because They Felt Unsafe	*YRBSS*					
Sports Concussion Past Year	*YRBSS*					
Electronically Bullied	*YRBSS*					
Bullied On School Property	*YRBSS*					
Drank Alcohol or Used Drugs Before Last Sexual Intercourse	*YRBSS*					
Ever Physically Forced to Have Sexual Intercourse	*YRBSS*					
Experienced Physical Dating Violence	*YRBSS*					
Experienced Sexual Dating Violence	*YRBSS*					
Do Not Always Wear a Seatbelt	*BRFSS*					
Fatalities per Vehicle Miles Traveled	*NHTSA*					
Traffic Fatality Rate	*NHTSA*					
Drivers Involved in Fatal Crash Under the Influence of Alcohol, Drugs, or Medication	*NHTSA*					
Drivers Involved in Fatal Crash Distracted	*NHTSA*					
Child Maltreatment Victimization Rate	*NCANDS*					
Child Maltreatment Fatality Rate	*NCANDS*					
Violent Crime Rate	*UCR*					
Rape Rate	*UCR*					
Property Crime Rate	*UCR*					
Suicide Rate	*NVSS*					
Homicide Rate	*UCR*					

Sustained Progress

Data from the National Highway Traffic Safety Administration indicate that traffic fatality rates and the proportion of drivers in fatal crashes who were distracted in Rhode Island are consistently below the national rates (Table 10). Crime rates in Rhode Island from the Uniform Crime Reports, specifically violent crime, property crime, and homicide rates, are regularly lower than the nation (Table 13). According to the National Vital Statistics Survey, Rhode Island also has consistently lower rates of suicide than the nation, though 2018 data were not yet available (Table 13).

Comparable to the Nation

High school student reports of texting and driving were first collected in 2013 and continue to be comparable to the nation according to the YRBSS (Table 1). Other violence indicators in the YRBSS that continue to be comparable to the nation for Rhode Island include high school student reports of rarely wearing a seat belt, missing school because a student felt unsafe, being electronically bullied, bullied on school property, using substances before last sexual intercourse, and experiencing physical dating violence (Table 5). According to the BRFSS, rates of adults reporting not always wearing a seat belt are also comparable to the national average (Table 8). RI is also

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comparable to the nation for its traffic fatality rate per vehicle miles traveled, child maltreatment fatality rate, and rape rate (Tables 12, 13).

New Concern

High school student reports of sports concussions, a new indicator to RI YRBSS in 2017, show RI students have a higher prevalence than the national average (Table 2); in particular, male, sexual minority, black, Hispanic, and multiracial students were more likely than those across the nation to suffer from a sports concussion (Tables 3,4). Having previously been comparable to the nation, RI reports of sexual dating violence among high school students are increasing over time and have surpassed the nation in 2017 (Table 5). This excess prevalence is highest in the region and holds for all gender, sexual orientation, and racial groups (Tables 7,8). Finally, in 2017, RI had two times the proportion of Drivers in Fatal crashes under the influence of alcohol, drugs, or medication compared to the nation (Table 10). This proportion was among the highest of the northeastern states, surpassed only by New Hampshire (Table 11).

Continuing Concern

Rhode Island high school student reports of carrying a weapon to school and physical fighting at school in the past year have continued to surpass the nation since 2015 (Table 1). RI high school students fare worse than the nation for weapon carrying at school in the past month for all gender, sexual orientation, and race groups except white students (Tables 3,4); however, the rate is comparable to other states in the region (Table 2). As for physical fights on school property, RI has the highest prevalence of all northeastern states, and male, sexual minority, Hispanic, white, and multiracial students fare worse than those across the nation (Tables 3,4). Similarly, reports of ever having been physically forced to have sexual intercourse have continued to exceed national rates since 2013 (Table 5). Rhode Island rates exceed all other states in the region (Table 6), and all gender, sexual orientation, and racial groups exceeded national values (Tables 7,8). Another ongoing concern for Rhode Island relative to the nation is child maltreatment victimization, which has been above the national average since 2011 (Table 12).

Table 1: RI vs. US Injury & Violence Indicators among High School Students (%), 2011-2017

% of Students (grades 9-12) Reporting:	2011			2013			2015			2017		
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US
Texting and Driving	--	--	--	36.5	41.4	**0.88**	45.7	41.5	**1.10**	37.3	39.2	**0.95**
Rarely or Never Wore Seat Belt	10.1	7.7	**1.31**	5.7	7.6	**0.75**	5.9	6.1	**0.97**	6.7	5.9	**1.14**
Carried Weapon at School Past Month	4.0	5.4	**0.74**	5.0	5.2	**0.96**	4.8	4.1	**1.17**	5.1	3.8	**1.34**
Physical Fight On School Property Past Year	7.8	12.0	**0.65**	6.3	8.1	**0.78**	9.1	7.8	**1.16**	10.5	8.5	**1.24**
Missed School Because Felt Unsafe	5.9	5.9	**1.00**	7.2	7.1	**1.01**	6.0	5.6	**1.07**	6.9	6.7	**1.03**
Sports Concussion Past Year	--	--	--	--	--	--	--	--	--	17.6	15.1	**1.17**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance Survey (YRBSS)*

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Table 2: RI vs. Region Violence among High School Students (%), 2011-2017

	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
Carried a Weapon at School Past Month										
2011	5.4	**4.0**	6.6	3.7	8.0	--	--	4.2	--	9.1
2013	5.2	**5.0**	6.6	3.1	7.1	--	2.7	4.0	--	10.4
2015	4.1	**4.8**	6.2	3.2	5.8	--	--	4.5	2.0	7.7
2017	3.8	**5.1**	5.4	2.7	5.3	3.6	--	3.4	2.2	6.9
Physically Fought on School Property Past Year										
2011	12.0	**7.8**	8.7	7.1	7.9	9.9	--	--	--	--
2013	8.1	**6.3**	--	4.6	5.7	6.9	--	--	--	--
2015	7.8	**9.1**	--	5.6	4.9	6.4	--	--	6.8	7.4
2017	8.5	**10.5**	--	5.8	5.2	--	--	--	7.4	6.5
Sports Concussion Past Year										
2017	15.1	**17.6**	16.8	--	--	14.4	--	--	14.3	17.9

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 3: RI vs. US Gender and Sexual Orientation Disparities in Injury & Violence Indicators (%), 2017

		Male	Female	Hetero-sexual	Gay or Lesbian	Bisexual	Gay, Lesbian, or Bisexual	Sexual Orientation Not Sure
	Carried a Weapon at School Past Month							
2017	RI	6.8	2.6	4.3	10.2	8.7	9.0	9.0
	US	5.6	1.9	3.4	7.1	5.5	5.9	4.9
	RI/US Ratio	**1.21**	**1.37**	**1.26**	**1.44**	**1.58**	**1.53**	**1.84**
	Physical Fight on School Property Past Year							
2017	RI	20.0	14.1	9.0	17.4	13.4	14.3	20.2
	US	17.1	13.0	8.3	9.9	9.5	9.6	11.8
	RI/US Ratio	**1.17**	**1.08**	**1.08**	**1.76**	**1.41**	**1.49**	**1.71**
	Sports Concussion Past Year							
2017	RI	20.0	14.1	16.3	23.1	16.1	17.7	29.0
	US	17.1	13.0	15.0	15.7	15.6	15.7	17.2
	RI/US Ratio	**1.17**	**1.08**	**1.09**	**1.47**	**1.03**	**1.13**	**1.69**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

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Table 4: RI vs. US Racial Disparities in Injury & Violence Indicators (%), 2017

		Asian*	Black	Hispanic	White	Multiple Races
	Carried a Weapon at School Past Month					
2017	RI	-	5.30	7.60	3.70	7.80
	US	2.2	3.6	3.5	3.8	4.1
	RI/US Ratio	-	**1.47**	**2.17**	**0.97**	**1.90**
	Physical Fight on School Property Past Year					
2017	RI	-	10.9	13.7	8.5	16.5
	US	3.7	15.3	9.4	6.5	9.2
	RI/US Ratio	-	**0.71**	**1.46**	**1.31**	**1.79**
	Sports Concussion Past Year					
2017	RI	--	28.7	22.2	14.3	16.7
	US	13.1	17.0	14.9	14.6	14.0
	RI/US Ratio	--	**1.69**	**1.49**	**0.98**	**1.19**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Sub-group data missing due to small sample size. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

Table 5: RI vs. US Relationship Injury & Violence Indicators among High School Students (%), 2011-2017

% of Students (grades 9-12) Reporting:	2011			2013			2015			2017		
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US
Electronically Bullied	15.3	16.2	**0.94**	14.3	14.8	**0.97**	12.4	15.5	**0.80**	14.2	14.9	**0.95**
Bullied On School Property	19.1	20.1	**0.95**	18.1	19.6	**0.92**	15.5	20.2	**0.77**	17.0	19.0	**0.91**
Drank Alcohol or Used Drugs Before Last Sexual Intercourse	20.8	22.1	**0.94**	--	22.4	**--**	--	20.6	**--**	17.3	18.8	**0.92**
Ever Physically Forced to Have Sexual Intercourse	6.9	8.0	**0.86**	8.5	7.3	**1.16**	8.1	6.7	**1.21**	8.8	7.4	**1.19**
Experienced Physical Dating Violence	--	--	**--**	8.4	10.3	**0.81**	8.8	9.6	**0.92**	9.0	8.0	**1.13**
Experienced Sexual Dating Violence	--	--	**--**	8.8	10.4	**0.85**	9.6	10.6	**0.90**	12.0	6.9	**1.74**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance Survey (YRBSS)*

Table 6: RI vs. Region Sexual Violence among High School Students (%), 2011-2017

	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
Ever Physically Forced to Have Sexual Intercourse										
2011	8.0	**6.9**	7.3	--	8.0	6.1	8.0	7.4	--	5.6
2013	7.3	**8.5**	9.2	--	7.6	5.7	8.4	--	--	7.6
2015	6.7	**8.1**	7.8	5.5	7.1	6.3	--	--	6.4	6.6
2017	7.4	**8.8**	7.5	6.8	7.3	5.8	--	--	8.7	6.1
Experienced Sexual Dating Violence										
2013	10.4	**8.8**	11.1	--	--	10.2	--	11.8	--	--
2015	10.6	**9.6**	11.5	7.5	--	11.7	--	14.7	9.3	--
2017	6.9	**12.0**	10.0	5.8	--	7.3	--	10.0	5.6	10.1

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance System (YRBSS)*

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Table 7: RI vs. US Gender and Sexual Orientation Disparities in Sexual & Physical Violence (%), 2017

		Male	Female	Hetero-sexual	Gay or Lesbian	Bisexual	Gay, Lesbian, or Bisexual	Sexual Orientation Not Sure
Ever Physically Forced to Have Sexual Intercourse								
2017	RI	7.6	9.5	7.0	19.1	18.5	18.6	13.6
	US	3.5	11.3	5.4	21.2	22.1	21.9	13.1
	RI/US Ratio	**2.17**	**0.84**	**1.30**	**0.90**	**0.84**	**0.85**	**1.04**
Experienced Sexual Dating Violence								
2017	RI	7.7	15.1	10.2	24.4	19.9	20.7	21.5
	US	2.8	10.7	5.5	12.1	16.8	15.8	14.1
	RI/US Ratio	**2.75**	**1.41**	**1.85**	**2.02**	**1.18**	**1.31**	**1.52**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Youth Risk Behavior Surveillance Survey (YRBSS)*

Table 8: RI vs. US Racial Disparities in Sexual & Physical Violence (%), 2017

		Asian*	Black	Hispanic	White	Multiple Races*
Ever Physically Forced to Have Sexual Intercourse						
2017	RI	--	6.2	10.0	8.4	8.0
	US	4.6	7.6	7.3	7.3	9.6
	RI/US Ratio	--	**0.82**	**1.37**	**1.15**	**0.83**
Experienced Sexual Dating Violence						
2017	RI	--	8.5	15.4	10.8	--
	US	7.7	4.8	6.9	6.9	9.6
	RI/US Ratio	--	**1.77**	**2.23**	**1.57**	--

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Sub-group data missing due to small sample size. *Source: Youth Risk Behavior Surveillance Survey (YRBSS)*

Table 9: RI vs. US Do Not Always or Nearly Always Wear a Seatbelt (%), 2016-2018

	2016	2017	2018
RI	5.70	4.00	5.90
US	6.00	5.70	6.30
RI/US Ratio	**0.95**	**0.70**	**0.94**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Behavioral Risk Factor Surveillance Survey (BRFSS)*

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Table 10: RI vs. US Traffic Fatalities, 2011-2017

	2011	2012	2013	2014	2015	2016	2017
Fatality Rate per 100 Million Vehicle Miles Traveled							
RI	0.84	0.82	0.84	0.66	0.57	0.64	1.04
US	1.10	1.14	1.10	1.08	1.15	1.19	1.16
RI/US Ratio	**0.76**	**0.72**	**0.76**	**0.61**	**0.50**	**0.54**	**0.90**
Traffic Fatalities Per 100,000							
RI	6.27	6.08	6.17	4.84	4.26	4.82	7.83
US	10.42	10.76	10.40	10.28	11.05	11.69	11.40
RI/US Ratio	**0.60**	**0.56**	**0.59**	**0.47**	**0.39**	**0.41**	**0.69**
Drivers in Fatal Crash Under the Influence of Alcohol, Drugs, or Medication (%)							
RI	4.9	17.2	9.6	10.9	15.5	12.1	20.4
US	13.9	14.0	13.5	12.1	11.4	11.0	10.5
RI/US Ratio	**0.29**	**1.23**	**0.71**	**0.90**	**1.36**	**1.10**	**1.94**
Drivers Involved in Fatal Crash Distracted (%)							
RI	3.7	2.3	7.2	0.0	1.7	4.5	2.9
US	7.1	6.9	6.6	6.8	6.7	6.2	5.7
RI/US Ratio	**0.52**	**0.33**	**1.09**	**0.00**	**0.25**	**0.73**	**0.51**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Fatality Analysis Reporting System (FARS)*

Table 11: RI vs. Region Drivers Involved in Fatal Crash Under the Influence (%), 2015-2017

	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2015	11.4	**15.5**	13.4	4.2	18.9	28.2	8.3	8.4	12.3	26.1
2016	11.0	**12.1**	7.5	11.8	16.6	29.5	9.4	7.6	9.3	33.8
2017	10.5	**20.4**	9.0	7.5	9.6	26.1	9.1	6.3	9.1	20.4

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: Fatality Analysis Reporting System (FARS)*

Table 12: RI vs. US Child Maltreatment, 2011-2017

	2011	2012	2013	2014	2015	2016	2017
Child Maltreatment Victimization per 1,000							
RI	14.2	14.8	14.6	16.1	15.1	14.2	14.9
US	8.8	8.8	8.8	9.1	9.2	9.1	9.1
RI/US Ratio	**1.61**	**1.68**	**1.66**	**1.76**	**1.64**	**1.56**	**1.64**
Child Maltreatment Fatalities per 100,000							
RI	1.40	0.50	0.50	2.80	0.00	1.93	2.41
US	2.11	2.18	2.09	2.14	2.26	2.36	2.32
RI/US Ratio	**0.66**	**0.23**	**0.24**	**1.31**	**0.00**	**0.82**	**1.04**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below the US average. *Source: National Data Archive on Child Abuse and Neglect (NCANDS)*

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Table 13: RI vs. US Crime, Suicide and Homicide Rates per 1,000, 2015-2018

	2015			2016			2017			2018		
	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio
Violent Crime*	2.43	3.73	**0.65**	2.39	3.98	**0.60**	2.34	3.95	**0.59**	2.19	3.81	**0.57**
Rape*	0.44	0.39	**1.13**	0.42	0.41	**1.02**	0.43	0.42	**1.02**	0.46	0.43	**1.07**
Property Crime*	18.98	24.87	**0.76**	17.88	24.51	**0.73**	17.59	23.63	**0.74**	16.61	22.00	**0.76**
Age-Adjusted Suicide**	0.112	0.133	**0.84**	0.112	0.135	**0.83**	0.118	0.140	**0.84**	--	--	**--**
Homicide*	0.027	0.055	**0.49**	0.027	0.054	**0.50**	0.020	0.053	**0.38**	0.015	0.050	**0.30**

NOTE: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios less than 0.86 indicate those consumption patterns where RI is below than the US average. *Sources: Uniform Crime Reports (UCR)*, National Vital Statistics System (NVSS)***

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Appendix

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Data Sources

Source	Sponsoring Agency	Methodology
Annual Homeless Assessment Report (AHAR) The Annual Homeless Assessment Report reports provide the latest counts of homelessness nationwide – including counts of individuals, persons in families, and special population groups such as veterans and chronically homeless people. https://www.hudexchange.info/hdx/guides/ahar/	United States Department of Housing and Urban Development (DHUD)	The AHAR is based on two data sources, 1) one-night, Point-in-Time (PIT) counts of both sheltered and unsheltered homeless populations and 2) Homeless Management Information System (HMIS) electronic administrative databases designed to record and store client-level information on homeless persons. **Frequency of Assessment:** Annual. **Target Population:** United States
Behavioral Risk Factor Surveillance System (BRFSS) A state-based system of health surveys that collects information on health risk behaviors, preventative health practices, and health care access primarily related to chronic disease and injury. http://www.cdc.gov/brfss/index.htm	The Centers for Disease Control and Prevention (CDC)	A cross-sectional telephone survey conducted by state health departments with technical and methodological assistance provided by the CDC. **Frequency of Assessment:** Data collected monthly every year. **Target Population:** Non-institutionalized adults in the United States.
Bureau of Labor Statistics (BLS) The BLS is the principal fact-finding agency for the Federal Government in the broad field of labor economics and statistics. The mission of BLS is to collect, analyze, and disseminate essential economic information to support public and private decision-making. http://www.bls.gov	United States Department of Labor	The Local Area Unemployment Statistics (LAUS) program produces labor force data. The Current Population Survey (CPS) is a monthly survey of households conducted by the Bureau of Census for the BLS, providing data on the labor force, employment, unemployment, persons not in the labor force, hours of work, earnings, and other demographic and labor force characteristics. **Frequency of Assessment:** Monthly and Annual. **Target Population:** United States

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Fatality Analysis Reporting System (FARS) A nationwide census providing NHTSA, Congress, and the American public yearly data regarding fatal injuries suffered in motor vehicle traffic crashes. http://www.nhtsa.gov/FARS	The National Highway Traffic Safety Administration (NHTSA)	The FARS is a crash census system in which a set of files has been built documenting all qualifying fatal crashes. To be included, a crash had to involve a motor vehicle traveling on a traffic way customarily open to the public, and must have resulted in the death of a motorist or a non-motorist within 30 days of the crash. **Frequency of Assessment:** Annual. **Target Population:** United States
National Child Abuse and Neglect Data System A voluntary national data system with annual data on child abuse and neglect across the country. https://www.acf.hhs.gov/cb/research-data-technology/reporting-systems/ncands	US Department of Health & Human Services, Children's Bureau	The National Child Abuse and Neglect Data System (NCANDS) is a voluntary data collection system that gathers information from all 50 states, the District of Columbia, and Puerto Rico about reports of child abuse and neglect. NCANDS was established in response to the Child Abuse Prevention and Treatment Act of 1988. **Frequency of Assessment:** Annual. **Target Population:** United States
National Survey of Drug Use and Health (NSDUH) A survey that provides national and state-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. http://nsduhweb.rti.org	The Substance Abuse and Mental Health Services Administration (SAMHSA)	A scientific random sample of US households, with the professional interviewer visiting each selected household. After answering a few general questions, one or two residents of the household may be asked to participate in the survey by completing an interview. **Frequency of Assessment:** Annual. **Target Population:** Individuals in the United States aged 12 and older.
National Vital Statistics System (NVSS) The National Center for Health Statistics (NCHS) collects and disseminates the Nation's official vital statistics. These data are provided through contracts between NCHS and vital registration systems legally responsible for the registration of vital events – births, deaths, marriages, divorces, and fetal deaths. http://www.cdc.gov/nchs/nvss.htm	The Centers for Disease Control and Prevention (CDC)	Data are provided through contracts between NCHS and vital registration systems legally responsible for the registration of vital events. Standard forms for the collection of the data and model procedures for the uniform registration of the events are developed and recommended for nationwide use. **Frequency of Assessment:** On-going; published annually. **Target Population:** All deaths occurring in the United States.

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Uniform Crime Reports (UCR) The UCR Program is a voluntary city, university and college, county, state, tribal and federal law enforcement program that provides a nationwide view of crime based on the submission of statistics by law enforcement agencies throughout the country. http://www.fbi.gov/about-us/cjis/ucr	Federal Bureau of Investigation (FBI)	Data collected from State agencies. Within the UCR Program, there are two methods of collecting crime data: the traditional Summary reporting system and the National Incident-Based Reporting System (NIBRS). To ensure these data are uniformly reported, the FBI provides contributing law enforcement agencies with a handbook that explains how to classify, define, and score offenses. **Frequency of Assessment:** Annual. **Target Population:** United States
United States Census The United States Census counts every resident in the United States. http://www.census.gov/programs-surveys/decennial-census.html	United States Census Bureau	The United States Census tells us who we are and where we are going as a nation. States use the census to redraw their congressional districts. Communities use it to plan where to build schools, roads, and hospitals. Governments use it to allot funds and support. **Frequency of Assessments:** Every 10 years. **Target Population:** Every resident in the United States.
Youth Risk Behavior Surveillance System (YRBSS) Monitors priority health-risk behaviors and the prevalence of obesity and asthma among youth and young adults. http://www.cdc.gov/HealthyYouth/yrbs	The Centers for Disease Control and Prevention (CDC)	YRBSS includes a national school-based survey conducted by CDC as well as state, territorial, and local school-based surveys conducted by education and health agencies. **Frequency of Assessments:** Bi-Annual. **Target Population:** Students in grades 9-12 in the United States.

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2019 State Profile — Rhode Island
National Mental Health Services Survey (N-MHSS)

The National Mental Health Services Survey (N-MHSS) is an annual survey of facilities providing mental health treatment. It is conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA). The N-MHSS collects data on the location, characteristics, services offered, and number of clients (collected every other year) in treatment at mental health treatment facilities (public and private) throughout the 50 states, the District of Columbia, U.S. territories, and other jurisdictions.

More information on the methodology used is available in the 2019 N-MHSS report:
https://www.samhsa.gov/data/data-we-collect/n-mhss-national-mental-health-services-survey

In Rhode Island, 63 mental health treatment facilities were included in the 2019 N-MHSS report, with a reference date of April 30, 2019. The survey response rate in Rhode Island was 92.9 percent.

Facility operation, by number and percent

	Facilities	
	No.	%
Private non-profit	57	90.5
Private for-profit	2	3.2
Public agency or department		
State mental health agency (SMHA)	1	1.6
Other state government agency or department	1	1.6
Regional/district authority or county, local, or municipal government	—	—
Tribal government	—	—
Indian Health Service	—	—
Department of Veterans Affairs	2	3.2
Other	—	—
Total	**63**	**100.0**

Note: Percentages may not sum to 100 percent due to rounding.

Service setting, by number and percent

	Facilities	
	No.	%
24-hour hospital inpatient	8	12.7
24-hour residential	22	34.9
Less-than-24 hour		
Partial hospitalization/day treatment	10	15.9
Outpatient	40	63.5
Total	**63**	

Notes: The number of facilities sums to more than the total, and percentages of facilities sum to more than 100 percent, because a facility may offer mental health treatment in more than one service setting.

Facility type, by number and percent

	Facilities	
	No.	%
Psychiatric hospital	2	3.2
General hospital	5	7.9
Residential treatment center for children	3	4.8
Residential treatment center for adults	18	28.6
Other type of residential treatment facility	—	—
Veterans Affairs medical center or other VA health care facility	2	3.2
Community mental health center (CMHC)	20	31.7
Partial hospitalization/day treatment facility	—	—
Outpatient mental health facility	12	19.0
Multi-setting mental health facility	1	1.6
Other	—	—
Total	**63**	**100.0**

Note: Percentages may not sum to 100 percent due to rounding.

Treatment approaches, by number and percent

	No.	%
Individual psychotherapy	53	84.1
Couples/family therapy	35	55.6
Group therapy	54	85.7
Cognitive behavioral therapy	51	81.0
Dialectical behavior therapy	44	69.8
Behavior modification	34	54.0
Integrated dual disorders treatment	50	79.4
Trauma therapy	41	65.1
Activity therapy	32	50.8
Electroconvulsive therapy	5	7.9
Telemedicine/telehealth therapy	3	4.8
Psychotropic medication	59	93.7
Other	1	1.6
None of these mental health treatment approaches are offered	—	—

Note: Facilities may provide more than one type of treatment approach.

Age groups served, by number and percent

	No.	%
All age categories[1]	13	20.6
Children (12 years or younger)	20	31.7
Adolescents (13–17 years)	25	39.7
Young adults (18–25 years)	56	88.9
Adults (26–64 years)	54	85.7
Seniors (65 years or older)	54	85.7

Note: Percentages sum to more than 100 percent, because a facility may accept clients from more than one age group.

[1] This created variable includes facilities that accept all of the following: children (12 years or younger), adolescents (13–17 years), young adults (18–25 years), adults (26–64 years), and seniors (65 years or older).

Supportive services and practices, by number and percent

	No.	%
Assertive community treatment (ACT)	17	27.0
Intensive case management (ICM)	12	19.0
Case management (CM)	52	82.5
Court-ordered outpatient treatment	42	66.7
Chronic disease/illness management (CDM)	27	42.9
Illness management and recovery (IMR)	27	42.9
Integrated primary care services	28	44.4
Diet and exercise counseling	34	54.0
Family psychoeducation	44	69.8
Education services	29	46.0
Housing services	25	39.7
Supported housing	14	22.2
Psychosocial rehabilitation services	26	41.3
Vocational rehabilitation services	29	46.0
Supported employment	22	34.9
Therapeutic foster care	2	3.2
Legal advocacy	13	20.6
Psychiatric emergency walk-in services	25	39.7
Suicide prevention services	49	77.8
Consumer-run (peer support) services	25	39.7
Screening for tobacco use	44	69.8
Smoking/tobacco cessation counseling	34	54.0
Nicotine replacement therapy	24	38.1
Non-nicotine smoking/tobacco cessation medications (by prescription)	24	38.1
Other	—	—
None of these services and practices are offered	2	3.2

Note: Facilities may provide more than one supportive service or practice.

For a symbol key, see the last page of this profile.

Facility licensing, certification, or accreditation, by number and percent

	No.	%
State mental health authority	53	84.1
State substance abuse agency	33	52.4
State department of health	30	47.6
State or local department of family and children's services	14	22.2
Hospital licensing authority	10	15.9
The Joint Commission	25	39.7
Commission on Accreditation of Rehabilitation Facilities (CARF)	17	27.0
Council on Accreditation (COA)	20	31.7
Centers for Medicare and Medicaid Services (CMS)	28	44.4
Other national organization or federal, state, or local agency	1	1.6

Note: Facilities may be licensed, certified, or accredited by more than one agency/organization.

Facility payment options, by number and percent

	No.	%
Cash or self-payment	47	74.6
Private health insurance	46	73.0
Medicare	44	69.8
Medicaid	59	93.7
State-financed health insurance plan other than Medicaid	46	73.0
State mental health agency (or equivalent) funds	39	61.9
State welfare or child and family services agency funds	26	41.3
State corrections or juvenile justice agency funds	15	23.8
State education agency funds	7	11.1
Other state government funds	25	39.7
County or local government funds	19	30.2
Community Service Block Grants	16	25.4
Community Mental Health Block Grants	22	34.9
Federal military insurance	31	49.2
U.S. Department of Veterans Affairs funds	12	19.0
IHS/Tribal/Urban (ITU) funds	1	1.6
Other	—	—

Note: Facilities may accept more than one type of payment.

Services in sign language for the deaf and hard-of-hearing and in languages other than English, by number and percent

	No.	%
Sign language	28	44.4
Any language other than English	42	66.7
Languages provided by staff		
Spanish	26	41.3
American Indian/Alaska Native languages	—	—
Other	11	17.5

Crisis intervention team, by number and percent

	No.	%
Within facility and/or offsite	41	65.1
No crisis intervention team	22	34.9

Note: Percentages may not sum to 100 percent due to the exclusion of facilities that did not respond to the question about having a crisis intervention team.

For a symbol key, see the last page of this profile.

Dedicated or exclusively designed programs or groups, by number and percent

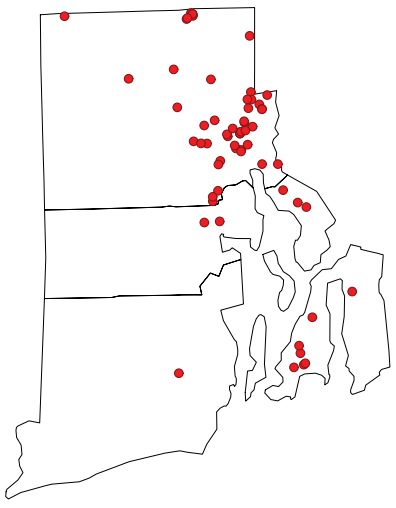
	No.	%
Children/adolescents with serious emotional disturbance (SED)	13	20.6
Transitional age young adults	7	11.1
Persons 18 years and older with serious mental illness (SMI)	39	61.9
Seniors or older adults	14	22.2
Persons with Alzheimer's or dementia	8	12.7
Persons with co-occurring mental and substance use disorders	41	65.1
Persons with eating disorders	3	4.8
Persons who have experienced trauma (excluding persons with a PTSD diagnosis)	27	42.9
Persons with a diagnosis of post-traumatic stress disorder (PTSD)	21	33.3
Persons with traumatic brain injury (TBI)	3	4.8
Veterans	7	11.1
Active duty military	2	3.2
Members of military families	3	4.8
LGBT clients	11	17.5
Forensic clients[1]	11	17.5
Persons with HIV or AIDS	6	9.5
Other special program or group	3	4.8
No dedicated or exclusively designed programs or groups offered	6	9.5

LGBT = lesbian, gay, bisexual, or transgender.
[1] Referred from the court/judicial system.

Symbol key (where applicable)

— Quantity is zero.

Location of treatment facilities



Data in this profile are from facilities that reported to the N-MHSS and are based on the survey's reference date, April 30, 2019.

The latest N-MHSS report, and other mental health reports, are available at: https://www.samhsa.gov/data/data-we-collect/n-mhss-national-mental-health-services-survey

Access the latest N-MHSS public use files at: https://datafiles.samhsa.gov

For information on individual facilities, access SAMHSA's Behavioral Health Treatment Services Locator at: https://findtreatment.samhsa.gov/

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Behavioral Health Statistics and Quality
www.samhsa.gov/data

https://www.samhsa.gov/data/quick-statistics

FY2022-2023 Rhode Island Substance Abuse Prevention Treatment and Community Mental Health Services Block Grant Needs Assessment Report

By

Amanda A. Roy, Jesse D. Sullivan, Candace Rodgers, Samantha Borden, Ashley Fontanez, Avery Leigland, Noah Locke, Sara D. Cottrill & L. A. R. Stein

Executive Summary

The purpose of the present needs assessment was to assess the state of behavioral healthcare in Rhode Island (RI) during the 2020-2021 fiscal year. Specifically, we aimed to assess the unmet service needs and critical gaps within the current system as well as any advances that have been made since the 2018-2019 needs assessment. We also sought to examine the impact of the COVID-19 pandemic on the state of behavioral healthcare services.

Data sources for the present needs assessment consist of the Rhode Island Behavioral Health Community Survey, which targets providers, consumers, and family members, and focus groups that were conducted with state-level administrators who were able to offer a unique perspective on what changes have been made to the RI system since the 2018-2019 needs assessment.

Main Findings

Survey

- Providers believe it would be beneficial to offer services in all areas we assessed, but most highly rated for both mental health and substance use were federally qualified health centers, domestic violence shelters, homeless shelters, and jails. Schools were rated high for mental health, but not as high for substance use.
- Most highly attended trainings are ethics and liability trainings and confidentiality trainings (i.e. HIPAA and 42 CFR, Part 2).
- quarter of the providers noted falling short servicing youth, early adolescents, adolescents, young adults, adults, and older adults with developmental disabilities, individuals with serious mental health issues, individuals who identify as LGBT+ and have serious mental health issues, individuals who misuse alcohol and/or other substances and identify as LGBT+ or children of military families, among others.
- Most highly rated barriers for clients utilizing services according to providers consisted of transportation and stigma.

Focus Groups

- The most salient theme from the focus groups was COVID-19, which in the context of the past year was to be expected.
- Advances were observed in Adolescent Care compared to the 2018 block grant.
- Themes that were more positive included adolescent care, outreach, cultural competency, funding, and telehealth. Themes that were more negative included housing, staffing, transportation, and the COVID-19 pandemic.

Body of Report

Methods

Survey

An online survey was administered to obtain a variety of views and opinions. This survey was geared towards individuals engaged in Rhode Island's Behavioral Healthcare system as providers, consumers, or family members of consumers. The number of questions in the survey varied depending on if the participant was a provider, consumer, or family member of a consumer. The survey was administered from December 2020 to March 2021, through the software program, Qualtrics.

Provider Survey

Participants: To recruit participants, personalized emails were sent out to the following listservs: behavioral and mental health (including the substance use and mental health leadership council of RI, NAMI, RICARES, BHLINK, and several hospitals and psychiatric facilities), homeless shelters (including the RI Coalition for the Homeless, House of Hope, and Amos House), Community Health Centers and Community Action Programs (including Thundermist health center, Providence Community Health Center, and East Bay Community Action Program), and the Governor's Council on Behavioral Health. Additionally, members of these listservs and stakeholders were given the survey to distribute. Outreach efforts were also engaged with established organizations serving minority populations such as Pride RI, AIDS Care Ocean State, PRYSM, and TGI Network of RI. The survey was also shared with more recently formed groups such as Black Lives Matter RI. Outreach included sharing the survey to social media groups in LGBTQ+ and BIPOC that appeared active at the time of data collection. Not all participants were compensated for their time, but instead were entered into a raffle, in which five individuals received a $25 gift card from CVS. Survey participants consisted of consumers of substance use and/or mental health services/treatment (N= 28), family members of consumers who use substance use and/or mental health services/treatment (N= 33), and providers (N= 224).

Materials and Procedures: The Providers Survey involved questions such as, "Do you work for a private, non-profit, or public agency" or "On a scale of 1 to 5, in your opinion how readily are you/is your agency able to meet service needs for Adolescents (14 to 17 years old), with respect to each of the following?" Where circumstances such as "having serious behavior

issues" were listed. Providers then rated their readiness on a scale of 1 to 5, 1 being "*greatly falls short*" and 5 being "*very easily meets needs*." Choices 6 and 7 were added to the scale in case a respondent (6) "*preferred not to respond*" or (7) the question "*does not apply*." In the Consumers Survey, consumers were given questions stating, "On a scale of 1 to 5, how severe are these barriers for you to receive mental health services." Barriers such as transportation, stigma, and costs of services/co-pays were listed. Each barrier was rated by the consumer on a 1 to 5 scale, 1 being "*not a barrier*" and 5 being an "*extreme barrier*." Options 6 and 7 were also added to this scale in case they chose not to respond (6), or the question wasn't applicable (7). Questions in the Family of Consumer Survey asked, "On a scale of 1 to 5, how important is it to offer substance use disorder services in the following environments, outside of behavioral health organizations?" With option 1 being "*not important at all*" and 5 being "*very important*," environments including homes, schools, and emergency departments were all listed. Similar to the provider and consumer survey, options 6 and 7 were also included. Respondents were contacted via emails obtained through listservs, and the demographic data was collected towards the end of the survey. In order to ensure that participants only responded to questions that were applicable to them as providers, consumers, or family members of consumers, skip/display logic was used throughout the surveys.

Analysis Plan: The data was cleaned and analyzed using SPSS version 26. There was a clear low response rate from consumers of substance use and/or mental health treatment and family members of those who utilize substance use and/or mental health treatment. Thus, a greater focus was placed on the provider response due to the bulk of survey respondents being providers.

Focus Group

Participants: Participants in the focus groups were persons with profound knowledge and experience within areas related to the combined mental health/substance use Block Grants. The purpose of these sessions was made aware to all participants. In total there were 12 individuals who participated across the two focus groups. Participants were reassured that their statements would remain anonymous and were asked to not discuss the proceedings with those outside the focus group as an extra layer of protection.

Procedure and Materials: Each focus group was conducted via Zoom and facilitated by trained graduate and undergraduate students (N= 3). This same research team of students, as well as state-level partners, developed the series of questions and probes utilized in the focus groups. One of the questions asked, "Have providers noted that there are specific subpopulations that are more affected by barriers to accessing services than others? If so, please describe/explain." If the response was deemed too vague, the probe for this question included asking about race, gender, income level, etc. The same list of questions was asked in each focus group for standardization purposes. Interviewees were informed that the focus groups were being recorded, and that notes would be taken in case of an objection during the transcript cleaning process. All questions were also typed out into the Zoom chat for participants to recall throughout the focus group duration. As there were multiple members of the research team on each Zoom call, they took turns co-moderating the focus group sessions and monitoring the chat feature. Focus groups took place in late February and early March 2021.

Analysis Plan: Each recording was transcribed through Amazon AWS and transcripts were cleaned by a selected group of undergraduate students, to solidify consistency with the corresponding recording. Once the transcripts were cleaned and cross-validated, they were assessed for recurring themes by three members of the research team. Thematic analysis was conducted using Atlas.TI version 9.

Results

Rhode Island Behavioral Health Community Survey

Providers

Our sample consisted of 224 providers working throughout the state. Table 1 shows a breakdown of the type of provider agencies they work for/are employed by.

Table 1. Breakdown of provider agencies by type

Agency Type	Frequency (%)
General Outpatient/Child and Adolescent Intensive Treatment Services	30 (13.4%)
Community Support Program	58 (25.9%)
Mental Health Psychiatric Rehabilitation Residence	10 (4.5%)

Assertive Community Treatment (ACT)	15 (6.7%)
Integrated Health Home (IHH)	28 (12.5%)
Acute Stabilization Unit (Emergency Room Diversion or Diversion from Inpatient Psychiatric)	8 (3.6%)
Inpatient Psychiatric Hospitalization	2 (0.9%)
Choice Center of Excellence	15 (6.7%)
Outpatient Narcotic Detoxification	4 (1.8%)
Opioid Treatment Program	24 (10.7%)
Substance Use Disorder- Residential	13 (5.8%)
Other	49 (21.9%)

The majority of our sample was made up of providers who came from community support program organizations, followed by "other", which included options like the Department of Corrections and Intensive Outpatient Psychiatric (IOP) services.

Table 2 illustrates the provider breakdown by catchment areas (i.e. areas of service).

Table 2. Catchment Areas where participants provided services

Catchment Area	Frequency (%)
Catchment Area 1 (Burriville, Cumberland, Lincoln, North Smithfield, Woonsocket)	29 (16.6%)
Catchment Area 2 (Pawtucket, Central Falls)	6 (3.4%)
Catchment Area 3 (Providence)	46 (26.3%)
Catchment Area 4 (Foster/Glocester, Scituate, Smithfield, Cranston, Johnston, North Providence)	14 (8.0%)
Catchment Area 5 (Coventry, East and West Greenwich, Warwick, and West Warwick)	15 (8.6%)
Catchment Area 6 (Block Island, Charlestown, Exeter, Hopkinton, Narragansett, North and South Kingston, Richmond and Westerly	11 (6.3%)
Catchment Area 7 (Barrington, Bristol, East Providence, Warren)	11 (6.3%)
Catchment Area 8 (Jamestown, Little Compton, Middletown, Newport, Portsmouth, and Tiverton)	35 (20.0%)
Statewide Service	8 (4.6%)

When asked what catchment area they worked in, most respondents selected Catchment Area 3: “Providence”, followed by Catchment Area 8 (Jamestown, Little Compton, Middletown, Newport, Portsmouth, and Tiverton).

When asked whether they worked for a private, non-profit, or public agency, 19 (12.6%) participants selected private, 106 (70.2%) selected non-profit, 23 (15.2%) selected public, and 3 (2%) selected other. When asked about what type of funding their agency received, 19 (25.3%) participants noted that they were funded by the block grant, 12 (16%) participants were funded by discretionary grants, and 44 (58.7%) participants reported being funded by other funding sources. When participants were asked to rate on a scale from 1 to 5 how the lack of state funding for programs impacts service provisions, more than half of respondents (n=114, 77.5%) scored this issue a 5 (highly impactful). When asked the same question of appropriate or timely reimbursement, the same impact was shown, with 92 (69.2%) rating this barrier as highly impactful. When asked to rate on a scale from 1 (*no communication*) to 10 (*perfect communication*) how well their agency communicates with government agencies, participants on average rated communication a 6.9 (SD = 2.1). When asked to rate their communication with other providers, participants on average rated communication a 7.2 (SD = 2.1).

When asked if their agency had previous experience working with peer recovery specialists (PRS), 100 (70.9%) said ‘yes’, while 41 (29.1%) said ‘no’. When asked how many PRS’s their agency employs, 26 (34.2%) participants reported employing 1-3 peers, 28 (36.8%) reported employing 4-6 peers, 8 (10.5%) reported employing 7-9 peers, and 14 (18.4%) reported employing 10 or more peers. When asked to report how important PRS’s are for client recovery, the majority of providers responded as either ‘very important’ (n=35, 35%), or ‘extremely important’ (n=34, 34%). When asked how useful PRS’s are in engaging clients in services, the majority of providers responded as either ‘moderately useful’ (n=30, 30.3%), or ‘very useful’ (n=40, 40.4%). When asked how useful PRS’s are in keeping clients in services, the majority of providers responded as either ‘very useful’ (n=30, 30.3%), or ‘moderately useful’ (n=41, 41.4%). Lastly, when asked how adequate reimbursements are for PRS’s, the majority of providers responded either ‘too low’ (n=37, 41.6%), or ‘about right’ (n=30, 33.7%).

Table 3 summarizes provider responses when asked how important it is to offer mental health and substance use services in the following areas outside of behavioral health organizations (BHO's).

Table 3. Responses to "How important would the following services be outside of BHOs?"

Services Provided:	Total N	Not Important	Somewhat Unimportant	Neither Important nor Unimportant	Somewhat Important	Very Important
In Home						
Substance Use	137	1 (0.7%)	2 (1.5%)	15 (10.9%)	35 (25.5%)	84 (61.3%)
Mental Health	132	0 (0.0%)	1 (0.8%)	4 (3.0%)	25 (18.9%)	102 (77.3%)
In Schools						
Substance Use	138	0 (0.0%)	3 (2.2%)	8 (5.8%)	30 (21.7%)	97 (70.3%)
Mental Health	131	0 (0.0%)	1 (0.8%)	1 (0.8%)	9 (6.9%)	120 (91.6%)
Emergency Department						
Substance Use	140	0 (0.0%)	1 (0.7%)	3 (2.1%)	16 (11.4%)	120 (85.7%)
Mental Health	134	0 (0.0%)	2 (1.5%)	1 (0.7%)	10 (7.5%)	121 (90.3%)
Primary Care Offices						
Substance Use	139	0 (0.0%)	1 (0.7%)	3 (2.2%)	35 (25.2%)	100 (71.9%)
Mental Health	134	0 (0.0%)	0 (0.0%)	4 (3.0%)	20 (14.9%)	110 (82.1%)
Jails						
Substance Use	140	0 (0.0%)	1 (0.7%)	1 (0.7%)	16 (11.4%)	122 (87.1%)
Mental Health	132	0 (0.0%)	1 (0.8%)	0 (0.0%)	7 (5.3%)	124 (93.9%)
Homeless Shelters						
Substance Use	141	0 (0.0%)	1 (0.7%)	2 (1.4%)	17 (12.2%)	121 (85.8%)
Mental Health	133	0 (0.0%)	1 (0.8%)	2. (1.5%)	5 (3.8%)	125 (94.0%)
Domestic Violence Shelters						
Substance Use	141	0 (0.0%)	0 (0.0%)	2 (1.4%)	19 (13.5%)	120 (85.1%)
Mental Health	134	0 (0.0%)	0 (0.0%)	0 (0.0%)	10 (7.5%)	124 (92.5%)
Senior Day Centers						
Substance Use	139	2 (1.4%)	7 (5.0%)	14 (10.1%)	59 (42.4%)	57 (41.0%)
Mental Health	132	0 (0.0%)	1 (0.8%)	6 (4.5%)	30 (22.7%)	95 (72.0%)
Federally Qualified Health Centers						
Substance Use	139	0 (0.0%)	0 (0.0%)	4 (2.9%)	23 (16.5%)	112 (80.6%)
Mental Health	132	0 (0.0%)	1 (0.8%)	3 (2.3%)	12 (9.1%)	116 (87.9%)
Assisted Living Facilities						

Substance Use	138	2 (1.4%)	6 (4.3%)	13 (9.4%)	58 (42.0%)	59 (42.8%)
Mental Health	131	0 (0.0%)	2 (1.5%)	9 (6.9%)	30 (22.9%)	90 (68.7%)
Other						
Substance Use	15	3 (20.0%)	1 (6.7%)	1 (6.7%)	1 (6.7%)	9 (60.0%)
Mental Health	12	1 (0.4%)	0 (0.0%)	0 (0.0%)	2 (16.7%)	9 (75.0%)

Results illustrate that mental health and substance use service providers believed it would be the most important to provide services in federally-qualified health centers (FHQC's), homeless shelters, domestic violence shelters, jails, emergency departments, and schools (though this resource was more pressing for mental health services than substance use services).

Table 4 highlights provider responses when asked how helpful different services would be for clients accessing either mental health or substance use services in RI.

Table 4. Responses to "How helpful would the following services be?"

How helpful would the following services be:	Total N	Not Helpful	Somewhat Helpful	Moderately Helpful	Helpful	Very Helpful
Providing Appointment Reminders						
Substance Use	140	0 (0.0%)	13 (9.3%)	11 (7.9%)	43 (30.7%)	73 (52.1%)
Mental Health	132	0 (0.0%)	5 (3.8%)	8 (6.1%)	35 (26.5%)	84 (63.6%)
Offering walk-in Appointments						
Substance Use	136	0 (0.0%)	3 (2.2%)	10 (7.4%)	28 (20.6%)	95 (69.9%)
Mental Health	130	2 (1.5%)	4 (3.1%)	7 (5.4%)	18 (13.8%)	99 (76.2%)
Offering services in language other than English						
Substance Use	139	0 (0.0%)	4 (2.9%)	7 (5.0%)	35 (25.2%)	93 (66.9%)
Mental Health	132	0 (0.0%)	5 (3.8%)	10 (7.6%)	19 (14.4%)	98 (74.2%)
Offering services for the deaf/hard of hearing						
Substance Use	136	0 (0.0%)	12 (8.8%)	18 (13.2%)	38 (27.9%)	68 (50.0%)
Mental Health	130	0 (0.0%)	15 (11.5%)	15 (11.5%)	27 (20.8%)	73 (56.2%)
Offering services for the visually or hearing impaired						
Substance Use	136	0 (0.0%)	16 (11.8%)	17 (12.5%)	35 (25.7%)	68 (50.0%)
Mental Health	131	0 (0.0%)	16 (12.2%)	17 (13.0%)	23 (17.6%)	75 (57.3%)
Offering Telemedicine Services						
Substance Use	139	0 (0.0%)	2 (1.4%)	4 (2.9%)	28 (20.1%)	105 (75.5%)
Mental Health	133	0 (0.0%)	2 (1.5%)	3 (2.3%)	20 (15.0%)	108 (81.2%)
Offering Services Online						

Substance Use	138	1 (0.7%)	10 (7.2%)	15 (10.9%)	33 (23.9%)	79 (57.2%)
Mental Health	132	1 (0.8%)	8 (6.1%)	10 (7.6%)	33 (25.0%)	80 (60.6%)
Offering Transportation Services						
Substance Use	140	0 (0.0%)	1 (0.7%)	2 (1.4%)	23 (16.4%)	114 (81.4%)
Mental Health	133	0 (0.0%)	1 (0.8%)	9 (6.8%)	14 (10.5%)	109 (82.0%)
Mobile Treatment Unit						
Substance Use	136	0 (0.0%)	3 (2.2%)	8 (5.9%)	24 (17.6%)	101 (74.3%)
Mental Health	131	1 (0.8%)	2 (1.5%)	12 (9.2%)	15 (11.5%)	101 (77.1%)
Bus Pass Voucher						
Substance Use	138	0 (0.0%)	3 (2.2%)	15 (10.9%)	23 (16.7%)	97 (70.3%)
Mental Health	131	1 (0.8%)	4 (3.1%)	13 (9.9%)	21 (16.0%)	92 (70.2%)
Flexible Payment Program						
Substance Use	130	1 (0.8%)	6 (4.6%)	17 (13.1%)	24 (18.5%)	130 (63.1%)
Mental Health	124	0 (0.0%)	9 (7.3%)	14 (11.3%)	18 (14.5%)	83 (66.9%)

Among the most helpful for mental health and substance use were: transportation services, providing a mobile treatment unit, providing bus pass vouchers, offering telemedicine services, offering walk-in appointments, and offering services in a language other than English (though this was rated more helpful for mental health services than substance use services).

Table 5 details the most prevalent barriers experienced by clients according to providers.

Table 5. Responses to "How frequently are the following barriers experienced by clients?"

Barriers	Total N	Never	Rarely	Sometimes Often	Often	Very Often
Transportation						
Substance Use	134	2 (1.5%)	11 (8.2%)	36 (26.9%)	31 (23.1%)	54 (40.3%)
Mental Health	128	3 (2.3%)	9 (7.0%)	32 (25.0%)	32 (25.0%)	52 (40.6%)
Stigma						
Substance Use	135	0 (0.0%)	7 (5.2%)	38 (28.1%)	33 (24.4%)	57 (42.2%)
Mental Health	131	1 (0.8%)	7 (5.3%)	35 (26.7%)	45 (34.4%)	43 (32.8%)
Not knowing how to access services						
Substance Use	138	0 (0.0%)	13 (9.4%)	49 (35.5%)	43 (31.2%)	33 (23.9%)
Mental Health	131	1 (0.8%)	7 (5.3%)	42 (32.1%)	45 (34.4%)	36 (27.5%)
Services offered at inconvenient times (no nights/ weekends)						
Substance Use	135	7 (5.2%)	37 (27.4%)	45 (33.3%)	30 (22.2%)	16 (11.9%)
Mental Health	127	4 (3.1%)	28 (22.0%)	38 (29.9%)	32 (25.2%)	25 (19.7%)

Not provided in a trauma responsive way						
Substance Use	137	15 (10.9%)	48 (35.0%)	40 (29.2%)	22 (16.1%)	12 (8.8%)
Mental Health	129	11 (8.5%)	43 (33.3%)	34 (26.4%)	19 (14.7%)	22 (17.1%)
Costs of services or co-pays						
Substance Use	132	8 (6.1%)	31 (23.5%)	50 (37.9%)	25 (18.9%)	18 (13.6%)
Mental Health	124	6 (4.8%)	22 (17.7%)	35 (28.2%)	39 (31.5%)	22 (17.7%)
Racial and ethnic difference						
Substance Use	135	11 (8.1%)	50 (37.0%)	35 (32.3%)	19 (16.2%)	20 (20.0%)
Mental Health	130	3 (2.3%)	38 (29.2%)	42 (18.8%)	21 (9.4%)	26 (11.6%)
Other						
Substance Use	16	3 (18.8%)	3 (18.8%)	0 (0.0%)	4 (25.0%)	6 (37.5%)
Mental Health	11	2 (18.2%)	2 (18.2%)	2 (18.2%)	1 (9.1%)	4 (36.4%)

For clients receiving mental health services, the most prevalent barriers were transportation, "other" (which consisted of barriers like a lack of culturally competent services or childcare), stigma, not knowing how to access services, services being offered at inconvenient times, costs, services not being provided in a trauma-responsive way, and racial-ethnic barriers. For clients receiving substance use services, the most prevalent barriers were stigma, transportation, other (again, lack of culturally competent services and childcare were mentioned), not knowing how to access services, racial-ethnic barriers, costs, services being offered at inconvenient times, and services not being provided in a trauma-responsive way.

The following tables (6-11) summarize responses regarding opinions of mental health needs being met for specific age groups in RI.

Table 6. Responses to infant's and toddler's (0 to 4 years old) needs being met

	Total N	Greatly Falls Short	Falls Short	Meets Needs	Easily Meets Needs	Very Easily Meets Needs
Have serious behavior issues	35	2 (5.7%)	9 (25.7%)	15 (42.9%)	4 (11.4%)	5 (14.3%)
Are suffering from abuse/ neglect	35	1 (2.9%)	6 (17.1%)	10 (28.6%)	10 (28.6%)	8 (22.9%)
Are born to women who have mental health condition	35	1 (2.9%)	8 (22.9%)	11 (31.4%)	9 (25.7%)	6 (17.1%)
Are born to women who use alcohol or drugs while pregnant	35	1 (2.9%)	7 (20.0%)	15 (42.9%)	5 (14.3%)	7 (20.0%)

Table 6 demonstrates that one quarter of our provider sample view themselves as falling short providing services for infants and toddlers with serious behavior issues, as well as infants and toddlers who were born to women who have a mental health condition.

Table 7. Responses to youth and early adolescence (5 to 13 years old) needs being met

	Total N	Greatly Falls Short	Falls Short	Meets Needs	Easily Meets Needs	Very Easily Meets Needs
Have serious behavior issues	58	1 (1.7%)	12 (20.7%)	22 (37.9%)	7 (12.1%)	16 (27.6%)
Are suffering from abuse/ neglect	59	2 (3.4%)	7 (11.9%)	22 (37.3%)	10 (16.9%)	18 (30.5%)
Have developmental disabilities	53	3 (5.7%)	15 (28.3%)	23 (43.4%)	5 (9.4%)	7 (13.2%)
Are suffering from serious health issues	54	2 (3.7%)	14 (25.9%)	25 (46.3%)	5 (9.3%)	8 (14.8%)
Are involved with the juvenile system	54	2 (3.7%)	13 (24.1%)	21 (38.9%)	7 (13.0%)	11 (20.4%)
Are experiencing discrimination or bullying because of their identity	57	2 (3.5%)	13 (22.8%)	21 (36.8%)	9 (15.8%)	12 (21.1%)

Table 7 demonstrates that approximately one quarter of our provider sample view themselves as falling short providing services for youth/early adolescents with developmental disabilities, youth/early adolescents suffering from serious health concerns, youth/early adolescents involved in the juvenile system, and youth/early adolescents experiencing discrimination or bullying because of their identity (i.e. race, ethnicity, sexual orientation, etc.).

Table 8. Responses to adolescence (14 to 17 years old) needs being met

	Total N	Greatly Falls Short	Falls Short	Meets Needs	Easily Meets Needs	Very Easily Meets Needs
Have serious behavior issues	69	2 (2.9%)	16 (23.2%)	20 (29.0%)	12 (17.4%)	19 (27.5%)
Are suffering from abuse/ neglect	70	1 (1.4%)	13 (18.6%)	23 (32.9%)	14 (20.0%)	19 (27.1%)
Have developmental disabilities	63	3 (4.8%)	16 (25.4%)	20 (31.7%)	15 (23.8%)	9 (14.3%)
Are suffering from serious health issues	62	2 (3.2%)	17 (27.4%)	24 (38.7%)	8 (12.9%)	11 (17.7%)
Are involved with the juvenile system	62	1 (1.6%)	17 (27.4%)	20 (32.3%)	10 (16.1%)	14 (22.6%)
Are experiencing discrimination or bullying because of their identity	69	2 (2.9%)	16 (23.2%)	25 (36.2%)	12 (17.4%)	14 (20.3%)

Table 8 demonstrates that approximately one quarter of our provider sample view themselves as falling short providing services for adolescents with serious behavioral health issues, adolescents with developmental disabilities, adolescents suffering from serious health concerns, adolescents involved in the juvenile system, and adolescents experiencing discrimination or bullying because of their identity (i.e. race, ethnicity, sexual orientation, etc.).

Table 9. Responses to young adults (18 to 25 years old) needs being met

	Total N	Greatly Falls Short	Falls Short	Meets Needs	Easily Meets Needs	Very Easily Meets Needs
Have developmental disabilities	108	3 (2.8%)	37 (34.3%)	37 (34.3%)	20 (18.5%)	11 (10.2%)
Are suffering from serious health issues	110	4 (3.6%)	22 (20.0%)	46 (41.8%)	20 (18.2%)	18 (16.4%)
Misuse alcohol or other substances	117	1 (0.9%)	13 (11.1%)	29 (24.8%)	29 (24.8%)	45 (38.5%)
Have serious and continuous mental health issues	118	1 (0.8%)	16 (13.6%)	33 (28.0%)	35 (29.7%)	33 (28.0%)
Have developmental disabilities and suffer from mental health or substance use issues	113	7 (6.2%)	31 (27.4%)	40 (35.4%)	15 (13.3%)	20 (17.7%)
Are mothers with mental health issues	115	2 (1.7%)	18 (15.7%)	40 (34.8%)	28 (24.3%)	27 (23.5%)
Are mothers with substance use issues	116	2 (1.7%)	16 (13.8%)	30 (25.9%)	29 (25.0%)	39 (33.6%)
Are involved with the criminal justice system	118	1 (0.8%)	17 (14.4%)	35 (29.7%)	28 (23.7%)	37 (31.4%)
Are homeless or at risk of homelessness	118	5 (4.2%)	25 (21.2%)	29 (24.6%)	26 (22.0%)	33 (28.0%)
Are financially disadvantaged	117	1 (0.9%)	21 (17.9%)	34 (29.1%)	25 (21.4%)	36 (30.8%)
Are experiencing discrimination or bullying because of their identity	116	1 (0.9%)	20 (17.2%)	47 (40.5%)	24 (20.7%)	24 (20.7%)
Are experiencing early or “first episode” psychosis	111	3 (2.7%)	25 (22.5%)	36 (32.4%)	25 (22.5%)	22 (19.8%)
Are suffering from abuse or neglect	117	1 (0.9%)	18 (15.4%)	42 (35.9%)	27 (23.1%)	29 (24.8%)

Are suffering serious mental health issues and have LGBTQ status	114	3 (2.6%)	31 (27.2%)	39 (34.2%)	21 (18.4%)	20 (17.5%)
Misuse alcohol or other substances and are Transgender	114	5 (4.4%)	26 (22.8%)	36 (31.6%)	22 (19.3%)	25 (21.9%)
Misuse alcohol or other substances and are children of military families	109	8 (7.3%)	25 (22.9%)	37 (33.9%)	16 (14.7%)	23 (21.1%)

Table 9 demonstrates that approximately one quarter of our provider sample view themselves as falling short providing services for young adults with developmental disabilities, young adults with co-occurring developmental disabilities and mental health/substance use concerns, young adults who are at risk of homelessness or are already homeless, young adults who are experiencing early or "first episode" psychosis, young adults who identify as LGBT+ with mental health concerns, young adults who misuse alcohol or other drugs who identify as transgender, and young adults who misuse alcohol or other drugs who were children of a military family.

Table 10. Responses to adults (26 to 64 years old) needs being met.

	Total N	Greatly Falls Short	Falls Short	Meets Needs	Easily Meets Needs	Very Easily Meets Needs
Have developmental disabilities	106	6 (5.7%)	29 (27.4%)	42 (39.6%)	15 (14.2%)	11 (10.4%)
Are suffering from infectious diseases	107	5 (4.7%)	13 (12.1%)	45 (42.1%)	21 (19.6%)	22 (20.6%)
Are suffering from serious health issues and have HIV/AIDS	107	5 (4.7%)	14 (13.1%)	47 (43.9%)	22 (20.6%)	17 (15.9%)
Misuse alcohol or other substances	115	3 (2.6%)	10 (8.7%)	32 (27.8%)	26 (22.6%)	44 (38.3%)
Have serious and continuous mental health issues	114	3 (2.6%)	10 (8.8%)	41 (36.0%)	27 (23.7%)	32 (28.1%)
Have developmental disabilities and also suffer from mental health or substance use issues	110	6 (5.5%)	24 (21.8%)	40 (36.4%)	21 (19.1%)	17 (15.5%)
Suffer from mental health or substance use issues and have	110	5 (4.5%)	17 (15.5%)	50 (45.5%)	22 (20.0%)	14 (12.7%)

a brain injury or cognitive impairment						
Suffer from mental health or substance use issues and are service members or veterans	110	6 (5.5%)	19 (17.3%)	41 (37.3%)	23 (20.9%)	18 (16.4%)
Suffer from mental health or substance use issues and are involved with the criminal justice system	113	3 (2.7%)	16 (14.2%)	36 (31.9%)	22 (19.5%)	36 (31.9%)
Suffer from mental health or substance use issues and are homeless or at risk of homelessness	112	3 (2.7%)	17 (15.2%)	39 (34.8%)	22 (19.6%)	31 (27.7%)
Are mothers with mental health issues	112	3 (2.7%)	12 (10.7%)	40 (35.7%)	29 (25.9%)	28 (25.0%)
Are mothers with substance use issues	110	3 (2.7%)	10 (9.1%)	38 (34.5%)	21 (19.1%)	38 (34.5%)
Are involved with the criminal justice system	111	4 (3.6%)	7 (6.3%)	41 (36.9%)	23 (20.7%)	36 (32.4%)
Are homeless or at risk of homelessness	113	4 (3.6%)	16 (14.3%)	37 (33.0%)	21 (18.8%)	33 (29.5%)
Are financially disadvantaged	113	2 (1.8%)	18 (15.9%)	37 (32.7%)	21 (18.6%)	33 (29.2%)
Are experiencing discrimination or bullying because of their identity	106	5 (4.7%)	13 (12.3%)	47 (44.3%)	20 (18.9%)	21 (19.8%)
Are suffering serious mental health issues and have LGBTQ status	107	5 (4.7%)	22 (20.6%)	43 (40.2%)	20 (18.7%)	16 (15.0%)
Have suffering serious mental health issues and are Transgender	104	5 (4.8%)	29 (27.9%)	39 (37.5%)	16 (15.4%)	15 (14.4%)
Are suffering serious mental health issues and are children of military	97	9 (9.3%)	18 (18.6%)	40 (41.2%)	13 (13.4%)	15 (15.5%)
Misuse alcohol or other substances and have LGBTQ Status	106	6 (5.7%)	17 (16.0%)	42 (39.6%)	18 (17.0%)	23 (21.7%)
Misuse alcohol or other substances and are Transgender	104	5 (4.8%)	23 (22.1%)	39 (37.5%)	14 (13.5%)	22 (21.2%)

Misuse alcohol or other substances and are children of military	100	10 (10.0%)	15 (15.0%)	37 (37.0%)	13 (13.0%)	23 (23.0%)

Table 10 demonstrates that approximately one quarter of our provider sample view themselves as falling short providing services for adults with developmental disabilities, adults with co-occurring developmental disabilities and mental health/substance use concerns, adults who identify as LGBTQ+ with mental health concerns, adults who were children of military families that have serious mental health issues, adults who misuse alcohol or other drugs who identify as transgender, and adults who misuse alcohol or other drugs who were children of a military family.

Table 11. Responses to older adults (64 years old and older) needs being met by agency

	Total N	Greatly Falls Short	Falls Short	Meets Needs	Easily Meets Needs	Very Easily Meets Needs
Have developmental disabilities	82	4 (4.9%)	26 (31.7%)	32 (39.0%)	12 (14.6%)	8 (9.8%)
Are suffering from serious health issues	87	4 (4.6%)	14 (16.1%)	36 (41.4%)	23 (26.4%)	10 (11.5%)
Misuse alcohol or other substances	88	2 (2.3%)	7 (8.0%)	31 (35.2%)	22 (25.0%)	26 (29.5%)
Have mental health issues and abuse alcohol or other substances	88	1 (1.1%)	9 (10.2%)	34 (38.6%)	19 (21.6%)	25 (28.4%)
Have developmental disabilities and suffer from mental health or substance use issues	84	4 (4.8%)	17 (20.2%)	33 (39.3%)	18 (21.4%)	12 (14.3%)
Are involved with the criminal justice system	86	4 (4.7%)	3 (3.5%)	31 (36.0%)	22 (25.6%)	26 (30.2%)
Are homeless or at risk of homelessness	88	4 (4.5%)	11 (12.5%)	31 (35.2%)	22 (25.0%)	20 (22.7%)
Are experiencing discrimination or bullying because of their identity	81	1 (1.2%)	11 (13.6%)	36 (44.4%)	19 (23.5%)	13 (16.0%)
Are suffering serious mental health issues and have LGBTQ status	84	4 (4.8%)	19 (22.6%)	35 (41.7%)	14 (16.7%)	11 (13.1%)
Are suffering serious mental health issues and are Transgender	81	5 (6.2%)	20 (24.7%)	31 (38.3%)	15 (18.5%)	10 (12.3%)

Are suffering serious mental health issues and are children of military	79	7 (8.9%)	17 (21.5%)	28 (35.4%)	14 (17.7%)	11 (13.9%)
Misuse alcohol or other substances and have LGBTQ Status	83	3 (3.6%)	16 (19.3%)	32 (38.6%)	15 (18.1%)	17 (20.5%)
Misuse alcohol or other substances and are Transgender	82	4 (4.9%)	17 (20.7%)	28 (34.1%)	17 (20.7%)	16 (19.5%)
Misuse alcohol or other substances and are children of military	80	8 (10.0%)	14 (17.5%)	24 (30.0%)	15 (18.8%)	18 (22.5%)

Table 11 demonstrates that approximately one quarter of our provider sample view themselves as falling short providing services for older adults with developmental disabilities, older adults with co-occurring developmental disabilities, mental health/substance use concerns, older adults who identify as LGBTQ+ with mental health concerns, older adults who were children of military families that have serious mental health issues, older adults who misuse alcohol or other drugs who identify as transgender, and older adults who misuse alcohol or other drugs who were children of a military family.

Table 12. Responses to “How often do employees utilize the following trainings?"

	Total N	Never	Rarely	Somewhat Often	Often	Very Often
Mental Health First Aid	141	3 (2.1%)	28 (19.9%)	33 (23.4%)	48 (34.0%)	29 (20.6%)
Clinical Administrative Supervision	128	6 (4.7%)	25 (19.5%)	18 (14.1%)	43 (33.6%)	36 (28.1%)
Clinical Supervisor Certification Course	121	14 (11.6%)	39 (32.2%)	27 (22.3%)	26 (21.5%)	15 (12.4%)
Children and Adolescent Mental Health	125	12 (9.6%)	38 (27.9%)	37 (27.2%)	28 (20.6%)	21 (15.4%)
Personality Disorders	136	12 (8.8%)	38 (27.9%)	37 (27.2%)	28 (20.6%)	21 (15.4%)
Suicide Prevention	144	4 (2.8%)	14 (9.7%)	38 (26.4%)	48 (33.3%)	40 (27.8%)
Working with grieving Children, Teens, and Families	134	16 (11.9%)	43 (32.1%)	29 (21.6%)	30 (22.4%)	16 (11.9%)
Identifying and responding to child sexual abuse	136	15 (11.0%)	42 (30.9%)	30 (22.1%)	31 (22.8%)	18 (13.2%)

Trauma and Substance use in families	145	5 (3.4%)	17 (11.7%)	30 (20.7%)	47 (32.4%)	46 (31.7%)
Co-Occurring disorder treatment for children and adolescents	133	15 (11.3%)	28 (21.1%)	32 (24.1%)	27 (20.3%)	31 (23.3%)
Substance use disorder in older adults	139	11 (7.9%)	19 (13.7%)	37 (26.6%)	36 (25.9%)	36 (25.9%)
Medication Assisted Treatment	132	10 (7.6%)	17 (12.9%)	25 (18.9%)	31 (23.5%)	49 (37.1%)
Addictions in LGBTQ+ population	134	15 (11.2%)	27 (20.1%)	48 (35.8%)	26 (19.4%)	18 (13.4%)
Affirmative care for transgender and gender non-conforming people	135	16 (11.9%)	37 (27.4%)	41 (30.4%)	25 (18.5%)	16 (11.9%)
Problem Gambling Services	133	28 (21.1%)	47 (35.3%)	33 (24.8%)	12 (9.0%)	13 (9.8%)
Internet Gaming and Gambling	133	33 (24.8%)	51 (38.3%)	25 (18.8%)	12 (9.0%)	12 (9.0%)
Addressing HIV, HCV, and other STD's in RI	134	19 (14.2%)	34 (25.4%)	33 (24.6%)	25 (18.7%)	23 (17.2%)
Women in the Criminal Justice System	136	26 (19.1%)	36 (26.5%)	35 (25.7%)	24 (17.6%)	15 (11.0%)
Surviving Change	134	20 (14.9%)	36 (26.9%)	38 (28.4%)	24 (17.9%)	16 (11.9%)
Client Engagement and Motivational Interviewing	137	9 (6.6%)	14 (10.2%)	25 (18.2%)	42 (30.7%)	47 (34.3%)
Legislative Advocacy	129	25 (19.4%)	49 (38.0%)	24 (18.6%)	14 (10.9%)	17 (13.2%)
Human Rights Officer	127	28 (22.0%)	39 (30.7%)	28 (22.0%)	16 (12.6%)	16 (12.6%)
Confidentiality (42 CFR, Part 2; HIPAA)	136	7 (5.1%)	13 (9.6%)	26 (19.1%)	33 (24.3%)	57 (41.9%)
Ethical and Liability Issues	137	7 (5.1%)	12 (8.8%)	23 (16.8%)	36 (26.3%)	59 (43.1%)
Ethical and Risk-Management Documentation Skills	136	9 (6.6%)	12 (8.8%)	32 (23.5%)	32 (23.5%)	51 (37.5%)
Claims Reimbursement	126	36 (28.5%)	41 (32.5%)	27 (21.4%)	9 (7.1%)	13 (10.3%)

Table 12 summarizes how often employees partake in the following trainings offered throughout the state. Results indicate that among the trainings offered throughout the state, employees most often enroll in those that center around ethics/liability issues and confidentiality (i.e. HIPAA) and least often enroll in trainings around gambling services and claims reimbursement.

State-Administrator Focus Groups

Two focus groups were conducted with state-level administrators in order to assess the system of behavioral healthcare within the state of RI. Each focus group was coded by two members of the research team (three coders in total), and 55% thematic agreement was reached (66.5% on the first focus group, 43% on the second). Most codes were derived from the 2018-2019 Block Grant Needs Assessment, with the exception of the COVID-19, telehealth, and staffing codes. There were a total of 13 major themes that our 12 participants mentioned throughout the focus groups. They are: COVID-19, Funding, Outreach, Housing, Cultural Competency, General Facilitators to Services and/or Treatment, Improvement Ideas, Staffing, Telehealth, Adolescent Care, General Barriers to Services and/or Treatment, Transportation, and Trauma Informed Care. Two additional themes for General Positive and General Negative healthcare-related quotes that did not fall into any of the aforementioned themes were also utilized.

Throughout the focus groups, participants mentioned the COVID-19 pandemic a total of 60 times in the context of the aforementioned themes. For example, one participant referenced the pandemics effects on the state of residential treatment throughout RI, “We have a couple of our detoxes that are at risk right now because they’re gonna have lower income and higher expenses because of purchasing PPEs, cleaning requirements. You used to have four people to a room, now you'd only have two people, so your income considerably drops.” While another mentioned more positive outcomes because of the pandemic, “Some of the positive things were around, um, telehealth; being able to provide services via telehealth, and some of our regulations changed to accommodate that, as long as the quick changes that were made with Medicaid to be able to financially support the changes.”

Participants mentioned the impact of funding 35 times throughout the focus groups in numerous contexts. Regarding the pandemic, funding was discussed in both positive and negative ways, such that costs for maintaining residential treatment centers increased while income decreased due to social distancing. However, COVID-specific grants aided in offsetting these costs as well as aiding in the transition into telemedicine/telehealth service use. It was also noted that funding for staff was subpar, with one participant stating that, “So, they could get paid just as much as working at Target then they could be paid in a good home, and that's sad but it's

true.” Participants also mentioned that funding has aided the increase in things such as culturally competent services and reimbursement for peer recovery services, while also mentioning that funding for all substance use is desired (as opposed to just a sole focus on opioids). Lastly, participants discussed the differences between long and short term funding streams and the impact they have on services throughout the state, with one participant stating that, “A lot of the funding that we have, the funding sources are time limited. And so it makes it hard, you know, in some cases agencies don't want to hire somebody if they know that the funding could go away in a year or two. So that, that presents a challenge.”

Participants mentioned outreach 32 times throughout the focus groups. Conversations around outreach were highly prevalent in the context of the COVID-19 pandemic, especially regarding the transition into telehealth services, the continued efforts on naloxone distribution and medication assisted treatment, and the impact of the pandemic on overdoses and overdose related deaths. Outside of the COVID-19 context, participants discussed a noted increase in outreach efforts like the HOPE initiative and the RI behavioral healthcare open beds website (ribhopenbeds.org), specific grants that fund outreach efforts (i.e. PATH), and finding creative ways to outreach to potential clients (i.e. podcasts). Participants also discussed the need for a better working definition of outreach throughout the state; rapid response efforts being informed by better data throughout the state; and the uneven distribution of outreach efforts throughout the state, with one participant noting that, “Definitely more outreach services and more agencies doing outreach services. Um, the issue is that we've got people falling all over each other doing outreach in certain areas, and then other areas of the state are completely uncovered”.

Throughout the focus groups, the housing theme was mentioned a total of 23 times. In regards to the COVID-19 pandemic, housing was impacted due to reduced room capacity, facilities being at risk for closing, COVID-19 relief dollars helping identify the number of available housing units, and the number of shelters, like the COVID-19 hotel program, which was also lauded as fostering engagement in services. For example, one participant noted, “ So what we're trying to do on the mental health and substance use side is where we have this like separate system of homeless service providers who really, for like at least the last 25 years, have needed to work more closely with the behavioral health organizations. Because we have the hotel programs, we've been able to engage a lot of our community mental health centers, um, to

coming into the hotels and having, um, warm handoffs with clients. So instead of going out with our outreach workers and you know, spending the nights on the street to engage individuals, it's a little easier for the staff to go to the hotels." Participants also noted that funders like Medicaid have been working to fund and improve home stabilization, while increased collaboration among providers has helped begin closing the gap, with one participant noting that, "100 people have been moved into stable housing." On the negative side, however, participants noted that there was still an increase in homelessness, that the lack of affordable/stable housing sometimes prevents the completion of a treatment plan, and in some cases, family reunification. This was also mentioned in the context of recovery, with one participant noting that "the lack of housing units is, is a huge problem. I mean, we know that when people are stably housed, they do better in their recovery. So this is a critical, you know, need for us".

Cultural Competency was discussed 17 times throughout the focus groups in numerous contexts, such as elderly clients not being able to fully access telehealth services due to limits with technology; successful partnerships with agencies like DORCAS International that aid in reducing cultural barriers by providing services such as translation; culturally competent trainings provided throughout the state and participants coming from diverse backgrounds; dissemination of information in both English and Spanish (e.g. PBS "opioids in the community" presentations); meaningful discussions with key stakeholders on how to collect data on race, ethnicity, and culture; and the focus on equality, but lack of equity in the state, with one participant noting, "There's still a great deal of people paying attention to equality, which is good. But there's a problem with equity when, as [Participant 2] said, people are having to continue to place that pie thinner and thinner, as far as their resources go, with less and less money and expecting to have positive outcomes and the ability to produce and provide quality services."

Throughout the focus groups several general facilitators that aided with the use/access of services and/or treatment were mentioned. These consisted of adaptability in the face of the COVID-19 pandemic, with one participant noting, "it started with the methadone clinics; there was a change in take home, so people were allowed to have their medications — take them home and lock boxes versus going to the clinics every day to reduce the concerns around COVID-19"; warm handoffs between providers to aid in the transition between services; having services like

the hotel program set up that make service accessibility mutually beneficial for both clients and providers; increased communication and memorandums of understanding between funders and providers; and the sharing and dissemination of resources between staff and agencies.

Participants noted various improvement ideas 17 times throughout the focus groups. These ideas consisted of starting more Assertive Community Treatment or Integrative Health Home teams; making better use of the technology we already have access to; better supporting individuals in the digital transition; incentivizing service delivery as a way to increase access to and quality of services; paying staff "appropriate rates" for services; funding mental health and substance use services equally (i.e. parity); making the state's Olmstead Plan a priority and finding outside advocates to take up the mantle; continue educating staff and providers on racial and ethnic inequality as a way to reduce barriers, and continuing to foster a representative workforce, with one participant noting that, "I mean, we've discussed workforce development in the past, and the need for that, because we don't have an adequate workforce that represents the populations that we're serving."

Staffing was mentioned 14 times throughout the focus groups in numerous contexts, such as not being able to retain staff/hiring difficulties, regardless of funding, with one participant noting that, "we've been getting a lot of different funding in to try to help us cope with COVID prices, and deal with a lot of these things, and just finding staff to do these jobs is really difficult. I mean, we're very grateful for the funding, but we've been having a difficult time getting things moving..."; unclear job/role responsibilities; staff not fulfilling their roles/duties (e.g. staff not actively engaging clients and providers); staff being able to fill multiple roles; and the workforce being strong despite the present barriers. This theme emerged out of the barriers to services and/or treatment themes.

Participants mentioned Telehealth a total of 13 times throughout the focus groups in both positive and negative contexts. Praises include some populations preferring telemedicine (i.e. youths/adolescents) and the increased access to services, especially for those who may have been previously harder to reach because of transportation barriers. Drawbacks consisted of a lack of anonymity; potential issues accessing telehealth services due to lack of available technology/wifi, with one participant noting, "When you talk about telehealth services, again, it's the accessibility, the equipment, that they may not have the equipment. I mean, people don't

think about it, but just in terms of being able to charge phones. If you don't have any place to get in from the outside, where are you going to charge the phones or whatever equipment that you know, you are using". Other drawbacks consisted of not being able to use the services because of a lack of tech knowledge or savvy and different levels of comfort with the use of telehealth for both clients and providers. This theme emerged out of the COVID-19 theme.

Adolescent Care was mentioned 12 times throughout the focus groups in numerous situations. Within the context of the COVID-19 pandemic, adolescent care was mentioned regarding youth usage and likability of telehealth services, as one participant noted, "While COVID is terrible, it also has been positive in some aspects, because there's some youth and young adults that don't like to sit on the proverbial Freudian couch. They'd rather take a walk, do it via telehealth, because then they don't have to do eye-to-eye therapy. And that's very important for youth." Other contexts include outreach and prevention efforts (i.e. student assistance; transitioning services to remote delivery...); specific services covered by the combined mental health/substance use block grant for youth (i.e. triage assessment offered by Bradley Hospital's KidsLink program); and worry over the increase of substance use/mental health concerns in youth populations.

General barriers to getting access to services and treatment were discussed a total of nine times throughout the focus groups, including; systemic barriers such as homelessness; staff not being able to advocate for their clients; and services being at capacity or not being accessible, with one participant noting that, "Because of the barriers of getting people into mental health treatment in particular, it's easier for us to provide those services on the street than it is to try to get them into, into agencies … the services, the agencies, for whatever reason, will not make some of the appointments or they don't have staff available to have the appointments."

Participants mentioned transportation a total of seven times throughout the focus groups. In the context of the COVID-19 pandemic, participants noted that there was greater hesitation around using public transportation services, while other barriers consisted of clunkiness with the transfer of the transportation contract, and the lack of available busses preventing individuals from being able to make it to their appointments on time. For example, one participant noted that, "transportation is a huge issue, so people who are homeless, for example, can't get to the agencies unless we have somebody to transport them. And they missed their appointments and

then they're just charged. Then they you know, um, decompensate and we're back to having them either in the prison or inpatient services. So it is a, it's a major issue."

Trauma Informed Care was mentioned five times throughout the focus groups in the context of the COVID-19 pandemic; treatment screenings, such that screeners sought trauma informed care training in order to better serve those they were working with; and increased trauma informed care training curriculums, and programs/services that emphasize taking a trauma-informed approach, such as Crisis Intervention Team Training and Crisis Response Services. For example, one participant noted, "There've been a recent interest in something called CAHOOTS [Crisis Assistance Helping Out On The Streets] and just crisis response services in general. As I pointed out, the law enforcement is becoming more interested in getting the crisis intervention training, also known as CIT training. But you also have a lot of people out there — legislators and other movers and shakers — interested in crisis services. And there's a model called CAHOOTS that's been getting some play. It was initiated in Oregon, but its peer-run, and as the peer-run services are becoming more popular in getting more into sort of the limelight, this model has been sort of introduced and come to the forefront. And I participated in a phone call, and I've worked in this field now for 20 years in Rhode Island, and I've never seen more peers more excited about anything before since I've been here."

Additionally, there were several other positive and negative themes that were discussed throughout the focus groups. On the positive side, participants noted that there were continued data collection efforts and dissemination of efforts despite the pandemic, along with innovative approaches to reducing COVID-19-related barriers; increases in culturally competent/trauma informed/recovery-oriented services; increases in training/education efforts and discussion (i.e. MAT, Crisis Intervention Services); and increased coordinated care. On the negative side, basic client needs not being met, increase in adolescent substance usage, and issues with managed care were discussed. For example, one participant mentioned, "...So if what you're being judged on is outcomes, there's a perverse incentive to discharge people who are extremely difficult and complicated clients. So you put in place policies that make it very difficult for these people to access services. When they don't access the services, for example, missing three appointments in a row, you discharge them, and you're no longer responsible for the outcome for those

individuals. So your outcomes look much better than they would if you were actually providing the services that you're supposed to be providing."

Conclusions

The 2020-2021 Block Grant Needs Assessment (BGNA) served as an update to the 2018-2019 BGNA and exhibited numerous strengths and weaknesses. This assessment also illuminated several key areas that still need work within the state, and some that have made significant strides in the past two years. Due to the COVID-19 pandemic, a full needs assessment was not feasible. Competition with several other agencies and organizations conducting their own assessments also reduced our participant pool even further. For this reason, our focus groups solely focused on gaining the perspective of state-level administrators, while the survey aimed to reach providers, consumers, and family members.

In regards to the survey, we had a higher volume of provider responses and fewer consumer and family responses. The lower response rates for both the consumer and family member surveys, though in line with the previous assessment (Tate et al., 2018), nevertheless limited our ability to analyze these responses in a more robust way. To address this in the future, we propose hosting quarterly town hall meetings to capture consumer and family member input at critical times throughout the year, and we propose to engage several advocacy agencies/organizations such as the RI National Alliance on Mental Illness (NAMI) chapter, Mental Health Authority (MHA), and the RI Community for Addiction Recovery Efforts (RICARES) to assist with these efforts. Additionally, expanded targeted outreach efforts, marketing, and including canvassers would aid in capturing a greater number of responses, especially from marginalized communities. We also had little range in responses when providers were asked to prioritize where they thought providing services would be helpful and what services would be helpful in making services accessible. Because of this we propose to update some Likert responses to be rank ordered so that we gain more variety in responses and broaden insight into what respondents view as most critical. Trends in responses also corresponded with the type of providers who participated. For example, we noticed a lot of individuals working with the Department of Corrections responded to the survey and one of the most prevalent responses was that services being provided in jails were in high need.

The provider survey suggested the following changes be made to the current system: 1) increase services in locations such as jails, domestic violence and homeless shelters, schools, and residential homes, senior and assisted living centers, among others. 2) Address barriers related to transportation, stigma, and the cost, time, and knowledge of how to access services. 3) Consider improving access to services by offering telemedicine, transportation assistance, mobile treatment, walk-in appointments, appointment reminders, flexible payment plans, and increasing culturally competent services (i.e. services in languages other than English, services for deaf/hard of hearing or visually impaired individuals, etc.). These trends were consistent when compared to the 2018-2019 provider responses.

The focus groups emphasized that trends in barriers observed from the 2018 BGNA are still prevalent (e.g. housing and transportation). However, strides have been made in areas like adolescent care, especially given the COVID-19 related promotion of Bradley Hospital's KidsLink, which is a behavioral health triage and referral service. Strides have also been made in cultural competency, outreach, and funding, though work in these areas still have room for improvement. Lastly, the COVID-19 pandemic had an impact on every facet of this needs assessment, from data collection to the findings. But under the circumstances, the transition to online platforms and telemedicine was adopted quickly and efficiently by providers across the continuum of care, and was generally accepted among these providers.

References

Tate, M.C., Rodgers, C., Pinchinat, M., Kunicki, Z. J., Risi, M., Cottrill, S., & Stein, L.A.R. (2019). Block Grant Needs Assessment Report. Created under a Memoranda of Understanding between the Dept of Behavioral Healthcare, Developmental Disabilities & Hospitals and The University of Rhode Island, Associate Director M. Brophy of BHDDH and LAR Stein of URI, with funding from the RI Executive Office of Health & Human Services ("Inter-Professional Workforce Development" grant), Principal Investigator-Stein, Project Director-S. Cottrill.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Youth

Priority Type: SAP

Population(s): PP

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 including use of electronic nicotine delivery system products (ENDS).

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of youth ages 12-17 reporting 30 day use of alcohol, marijuana, prescription drugs (past year, non-medical use of pain relievers), and tobacco products including electronic nicotine delivery system products (ENDS; ever used)

Baseline Measurement: 30 day use of cigarettes: 3.79 %; 30 day use of marijuana: 8.61%%; 30 day use of alcohol: 10.39%; ever used e-cigarettes 40.3%; past year non-medical use of pain relievers: 2.38%

First-year target/outcome measurement: Stabilization of reported 30 day use of alcohol, marijuana, prescription drugs, tobacco, and ENDS products by junior high/middle school and high school students in municipalities across the state.

Second-year target/outcome measurement: One percentage point decrease in reported 30 day use of alcohol, marijuana, prescription drugs, tobacco, and ENDS products by junior high/middle school and high school students in municipalities across the state.

Data Source:

Rhode Island Student and Youth Risk Behavioral Surveys (RISS; RI YRBS)

Description of Data:

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

Data issues/caveats that affect outcome measures:

The RISS was administered in 2020 over a longer period to allow for schools to participate due to the COVID-19 pandemic. It was completed in the spring of 2021 and our evaluator was able to keep separate who participated in what school year for the sake of data quality. Municipal level data is only available from the RISS and the YRBS provides state estimates.

Indicator #: 2

Indicator: Percentage of youth ages 12-17 reporting perception of risk of harm associated with substance misuse

Baseline Measurement: Perception of risk of harm for alcohol: 64%; Perception of risk of harm for marijuana: 44%; Perception of risk of harm for prescription drugs: 76%

First-year target/outcome measurement: Increase perception of risk of harm for substances by 2% (based on baseline)

Second-year target/outcome measurement: Increase perception of risk of harm for substances by 2% (based on first year target)

Data Source:

Rhode Island Student and Youth Risk Behavior Surveys

Description of Data:

The RI Student Survey (RISS) is a risk and prevalence survey that is administered bi-annually in nearly every middle and high school. The Youth Risk Behavior Survey (YRBS) 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 2020 over a longer period to allow for schools to participate due to the COVID-19 pandemic. It was completed in the spring of 2021 and our evaluator was able to keep separate who participated in what school year for the sake of data quality. Municipal level data is only available from the RISS and the YRBS provides state estimates.

Priority #: 2

Priority Area: Persons Who Inject Drugs

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

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

Strategies to attain the goal:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of unique contacts who met with a recovery coach through Anchor's ED program and/or recovery community center ED outreach

Baseline Measurement: 1,200

First-year target/outcome measurement: 1,200

Second-year target/outcome measurement: 1,200

Data Source:

Anchor ED and/or recovery community center ED reporting to the BHDDH Contract Monitoring Unit

Description of Data:

Our goal is to continue to reach about 100 new individuals each month through this program. Historically, this data has been reported to us from Anchor
ED as a requirement of their contract each month. However, it is possible that these responsibilities will be subsumed by the recovery community centers, as part of their contracts currently being finalized. It will be aggregated to an annual total for reporting.

Data issues/caveats that affect outcome measures:

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

Indicator #: 2

Indicator: Number of people who received outreach/contact with a recovery coach through Anchor MORE/recovery community center outreach programs

Baseline Measurement: 7,400

First-year target/outcome measurement: 7,450

Second-year target/outcome measurement: 7,500

Data Source:

Anchor MORE reporting to the BHDDH Contract Monitoring Unit and/or recovery community center reporting to the BHDDH Contract Monitoring Unit

Description of Data:

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

Data issues/caveats that affect outcome measures:

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

Priority #: 3

Priority Area: Individuals Experiencing Homelessness

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.

Strategies to attain the goal:

1. Conduct outreach to individuals experiencing homelessness to determine status of chronic or long-term homelessness, including conducting Vulnerability Index (VI) to add individuals to the State's consolidated housing wait list through the Housing Management Information System (HMIS).
2. Ensure provider perform Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) to determine service needs.
3. Participate in the chronic homeless housing wait list work group managed through the statewide Continuum of Care.
4. Engage individuals in supportive services.
5. Implement SSI/SSDI Outreach, Access, and Recovery (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: N/A

First-year target/outcome measurement: 120

Second-year target/outcome measurement: 120

Data Source:

Homeless Management Information System (HMIS)

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:

Currently, access to HMIS data is limited due to a new vendor in place. We hope this will change by the time we report on this metric in December 2021.

Indicator #: 2

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

Baseline Measurement: N/A

First-year target/outcome measurement: 85%

Second-year target/outcome measurement: 85%

Data Source:

SAMHSA SOAR OAT data base

Description of Data:

Description of data: Provides state data on SOAR approval rates.

Data issues/caveats that affect outcome measures:

N/A

Priority #: 4

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

Priority Type: MHS

Population(s): ESMI, Other

Goal of the priority area:

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

Strategies to attain the goal:

Continue to implement the Healthy Transitions grant activities beyond the life of the grant at the Labs operated though the Community Care Alliance which provides services to eligible individuals ages 16-25 living in the 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. Expand services to two new Healthy Transitions sites in Providence and Newport.

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: 68 youth and young adults

First-year target/outcome measurement: 100 youth and young adults

Second-year target/outcome measurement: 100 youth and young adults

Data Source:

Healthy Transitions contract monitor reporting from service providers to BHDDH

Description of Data:

All contracts, whether funded by discretionary funding or Block grant funding, include data reporting requirements including this metric.

Data issues/caveats that affect outcome measures:

One of the provider sites did not contract with BHDDH this year and therefore, we could not require them to report their data via contractual obligation. Therefore, our numbers are lower than expected.

Priority #: 5

Priority Area: Adults Diagnosed 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.

Strategies to attain the goal:

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: 262 readmits per 1,000

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

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

Data Source:

MMIS

Description of Data:

Medicaid claims data for IHH/ACT members

Data issues/caveats that affect outcome measures:

Previously, this data was reported by State Fiscal Year; however, all future reporting will be shifted to align with the MACPRO (CMS) reporting which is based on the Calendar Year.

Indicator #: 2

Indicator: Number of ER admits by IHH/ACT clients per 1,000

Baseline Measurement: 108 ER admits per 1,000 clients

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

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

Data Source:

MMIS

Description of Data:

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

Data issues/caveats that affect outcome measures:

N/A

Priority #: 6

Priority Area: Older Adults with SMI

Priority Type: MHS

Population(s): SMI, Other (Older Adults)

Goal of the priority area:

To increase access to services for older adults with SMI

Strategies to attain the goal:

Targeted outreach for BH Link to older adults

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of unique individuals assessed by BH Link age 60+

Baseline Measurement: 7.2%

First-year target/outcome measurement: 8%

Second-year target/outcome measurement: 9%

Data Source:

BHDDH Pulse Deck Reporting to EOHHS

Description of Data:

BHDDH regularly meets and discusses data with EOHHS. This is one of the metrics we provide on a regular basis.

Data issues/caveats that affect outcome measures:

None at this time

Priority #: 7

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.

Strategies to attain the goal:

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 calls made to Kid's Link

Baseline Measurement: 6,127 calls

First-year target/outcome measurement: 5,000 calls

Second-year target/outcome measurement: 5,000 calls

Data Source:

Kid's Link reporting metrics from Bradley Hospital

Description of Data:

Data issues/caveats that affect outcome measures:

Possible duplication on individuals

Indicator #: 2

Indicator: Number of participants (families with children meeting criteria for SED) who receive

evidence-based parenting, peer support, education workshops, and/or support groups

Baseline Measurement: 988 participants

First-year target/outcome measurement: 900 families with children

Second-year target/outcome measurement: 900 families with children

Data Source:

MIS

Description of Data:

Includes the three funded programs that DCYF manages to support children meeting the criteria for SED. This includes YAP and PSN's two programs, Family Preservation and Family Partners.

Data issues/caveats that affect outcome measures:

N/A

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023.
ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: Planning Period End Date:

Activity (See instructions for using Row 1.)	Source of Funds									
	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	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (SABG)[b]
1. Substance Abuse Prevention[c] and Treatment	$7,675,190.00		$0.00	$8,532,941.00	$271,468.00	$0.00	$0.00		$4,554,243.00	$4,443,370.00
a. Pregnant Women and Women with Dependent Children[c]	$319,166.00									
b. All Other	$7,356,024.00			$8,532,941.00	$271,468.00				$4,554,243.00	$4,443,370.00
2. Primary Prevention[d]	$6,763,286.00		$0.00	$2,602,941.00	$0.00	$400,000.00	$0.00		$2,211,764.00	$1,400,000.00
a. Substance Abuse Primary Prevention	$6,763,286.00			$2,602,941.00		$400,000.00			$2,211,764.00	$1,400,000.00
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	$759,920.00			$653,152.00	$1,251,246.00				$356,106.00	$307,546.00
10. Crisis Services (5 percent set-aside)										
11. Total	**$15,198,396.00**	**$0.00**	**$0.00**	**$11,789,034.00**	**$1,522,714.00**	**$400,000.00**	**$0.00**	**$0.00**	**$7,122,113.00**	**$6,150,916.00**

[a] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

[c] Prevention other than primary prevention

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

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Footnotes:
Medicaid dollars are kept within a budget at another department and do not appear under the budget of the SSA.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023.
Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

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

Activity (See instructions for using Row 1.)	Source of Funds									
	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	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[e]		$140,000.00						$325,000.00		
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$534,259.00		$1,049,326.00				$306,996.00		$531,000.00
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care		$3,395,200.00		$4,934,966.00				$1,609,469.00		$3,106,531.00
9. Administration (excluding program/provider level)[f] MHBG and SABG must be reported separately		$267,129.00		$419,738.00	$1,251,246.00			$153,498.00		$265,133.00
10. Crisis Services (5 percent set-aside)[g]		$1,006,000.00						$675,000.00		$1,400,000.00
11. Total	**$0.00**	**$5,342,588.00**	**$0.00**	**$6,404,030.00**	**$1,251,246.00**	**$0.00**	**$0.00**	**$3,069,963.00**	**$0.00**	**$5,302,664.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

[d] Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[e] While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[f] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

[g] Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	15,306	187
2. Women with Dependent Children	28,617	1,332
3. Individuals with a co-occurring M/SUD	52,547	15,401
4. Persons who inject drugs	20,000	4,202
5. Persons experiencing homelessness	2,698	1,002

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

3. Individuals with a co-occurring M/SUD = 52,547 Calculations 1. Pregnant women a. % of RI adults 18+ who need to access treatmenta = 8.95% (2018-2019 NSDUH) b. # of RI females ages 20-44 = 171,026 (Estimated 2019 Census) c. Calculation: 171,026 x 0.0895 = 15,306 2. Women with Dependent Children a. % of RI adults 18+ who need to access treatmenta = 8.95% (2018-2019 NSDUH) b. # of RI females ages 20-60 = 319,739 (Estimated 2019 Census) c. Calculation: 319,739 x 0.0895 = 28,617 3. Individuals with a co-occurring M/SUD a. % of youth 12-17 who need to access treatmenta,b = 1.7% (2019 NSDUH) b. % of adults 18+ who need to access treatmenta,b = 3.8% (2019 NSDUH) c. # of RI residents ages 10+ = 955,405 (Estimated 2019 Census) d. Calculation: 955,405 x (0.017 + 0.038) = 52,547 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: Due to a new vendor for the HMIS system, we have limited access to the HMIS data system at this time. Therefore, we utilized the homeless individuals count from the last Block grant application. Once we have access, we can update this figure.

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Table 4 SABG Planned Expenditures

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

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
1 . Substance Use Disorder Prevention and Treatment[3]	$3,837,595.00	$4,554,243.00	$4,443,370.00
2 . Primary Substance Use Disorder Prevention	$3,381,643.00	$2,211,764.00	$1,400,000.00
3 . Early Intervention Services for HIV[4]			
4 . Tuberculosis Services			
5 . Administration (SSA Level Only)	$379,960.00	$356,106.00	$307,546.00
6. Total	**$7,599,198.00**	**$7,122,113.00**	**$6,150,916.00**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

[3]Prevention other than Primary Prevention

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[4]For the purpose of determining which states and jurisdictions 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 (SABG); 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 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 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 will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Table 5a SABG Primary Prevention Planned Expenditures

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

A		B		
Strategy	IOM Target	FFY 2022		
		SA Block Grant Award	COVID-19[1]	ARP[2]
1. Information Dissemination	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
2. Education	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
3. Alternatives	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
4. Problem Identification and Referral	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
	Universal			

5. Community-Based Process	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
6. Environmental	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
7. Section 1926 Tobacco	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
8. Other	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$0**	**$0**	**$0**
Total SABG Award[3]		**$7,599,198**	**$7,122,113**	**$6,150,916**
Planned Primary Prevention Percentage		**0.00 %**	**0.00 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

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

Activity	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
Universal Direct	$1,859,904	$1,459,764	$910,000
Universal Indirect	$1,014,493	$110,588	$280,000
Selective	$338,164	$597,176	$140,000
Indicated	$169,082	$44,235	$70,000
Column Total	**$3,381,643**	**$2,211,763**	**$1,400,000**
Total SABG Award[3]	**$7,599,198**	**$7,122,113**	**$6,150,916**
Planned Primary Prevention Percentage	**44.50 %**	**31.05 %**	**22.76 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

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

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☑	☐	☐
Tobacco	☑	☐	☐
Marijuana	☑	☐	☐
Prescription Drugs	☐	☐	☐
Cocaine	☐	☐	☐
Heroin	☐	☐	☐
Inhalants	☐	☐	☐
Methamphetamine	☐	☐	☐
Bath salts, Spice, K2)	☐	☐	☐
Targeted Populations			
Students in College	☐	☐	☐
Military Families	☐	☐	☐
LGBTQ	☑	☐	☐
American Indians/Alaska Natives	☐	☐	☐
African American	☐	☐	☐
Hispanic	☑	☐	☐
Homeless	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☐	☐	☐

Underserved Racial and Ethnic Minorities	☐	☐	☐

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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Table 6 Non-Direct Services/System Development [SA]

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

Activity	FFY 2022				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems		$70,875.00			
2. Infrastructure Support	$229,672.00	$130,000.00		$90,000.00	$90,000.00
3. Partnerships, community outreach, and needs assessment	$56,609.00	$21,270.00			
4. Planning Council Activities (MHBG required, SABG optional)					
5. Quality Assurance and Improvement	$11,322.00				
6. Research and Evaluation		$142,114.00		$85,000.00	$85,000.00
7. Training and Education	$106,749.00	$190,000.00		$90,000.00	$90,000.00
8. Total	**$404,352.00**	**$554,259.00**	**$0.00**	**$265,000.00**	**$265,000.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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Table 6 Non-Direct-Services/System Development [MH]

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

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems	$91,200.00			$91,200.00		
2. Infrastructure Support						$400,000.00
3. Partnerships, community outreach, and needs assessment	$95,000.00	$125,000.00		$95,000.00	$125,000.00	
4. Planning Council Activities (MHBG required, SABG optional)	$65,000.00			$65,000.00		
5. Quality Assurance and Improvement						
6. Research and Evaluation	$95,000.00	$120,000.00	$85,000.00	$95,000.00	$120,000.00	$85,000.00
7. Training and Education	$153,000.00	$100,000.00	$25,000.00	$153,000.00	$100,000.00	$25,000.00
8. Total	**$499,200.00**	**$345,000.00**	**$110,000.00**	**$499,200.00**	**$345,000.00**	**$510,000.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15,2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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Environmental Factors and Plan

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

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] 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.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

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.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] 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.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD 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.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] 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 M/SUD include: developing models for inclusion of M/SUD 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.[30] 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 M/SUD 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 homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD 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.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] 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.[36] 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.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD 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.[39] 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 M/SUD 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.[40]
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.[41] 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.

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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 included 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 (PCHM) initiative in Rhode Island. PCMH-Kids is extending the transformation of the state's primary care practices to children. Through SOR and SBIRT grants, Community Health Teams will continue for the foreseeable future.
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. This will continue through September 2021.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and 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. Despite SIM grant closing out shortly, this steering committee will continue its work and is currently exploring applying for other grants, specifically under Medicaid and CMS.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? (●) Yes ( ) No

b) and Medicaid? (●) Yes ( ) No

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

BHDDH is working collaboratively with the Office of the Health Insurance Commissioner and the Division of Medicaid to identify parity issues, particularly around race and ethnicity.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? (●) Yes ( ) No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education (●) Yes ( ) No

b) Health risks such as

ii) heart disease (●) Yes ( ) No

iii) hypertension (●) Yes ( ) No

iv) high cholesterol (●) Yes ( ) No

v) 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?

Our managed care organizations responsible for Medicaid and commercial insurances continue to struggle with implementing parity provisions.

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

Not at this time.

Please indicate areas of technical assistance needed related to this section

This may be an area in which we explore technical assistance in the future.

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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**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD 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)[45].

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."[46]

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 status[47]. 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 populations[48]. 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, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD 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.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

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, sexual orientation, gender identity, 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 M/SUD 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) Standards? (•) Yes ( ) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ( ) Yes (•) No

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

Due to turnover in the epidemiologist position, we had a late start in the creation of a health disparity impact plan for the Block Grant.
There is a current plan to focus on this initiative in early 2022.

Please indicate areas of technical assistance needed related to this section

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3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its 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 M/SUD 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 M/SUD 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. SAMHSA's Evidence Based Practices Resource Center 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. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

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 General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. 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."[53] 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 M/SUD 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)**[54] are best practice guidelines for the SUD treatment. SAMHSA 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)**[55] was developed to help move the latest information available on effective M/SUD 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 M/SUD practices that work. KIT 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.

[49] 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

[50] 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.

[51] 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.

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

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) 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 focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

The state's Department of Administration is exploring the creation of a statewide risk assessment for all vendors who bid/receive contracts. As this work progresses, it may inform our purchasing processes.

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

None at this time.

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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 service efforts 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 outcomes 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.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

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). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. 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 Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG 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 new Healthy Transitions grant, the state is now offering Coordinated Specialty Care in four 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.) With the COVID-19 supplemental funds, we're exploring a new modified Healthy Transitions site that will be a pilot study into a reduced staff pattern for similar CSC services.

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

The state is has implemented a communication plan that addresses stigma and has created resource guides to help inform youth and young adults of available resources. All 4 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 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 2022 and FFY 2023 for your state's ESMI programs including psychosis?

RI plans to continue to implement the Healthy Transitions program through the two original sites through billing all billable services but possibly using the 10% set aside to support the remainder of services that are not reimbursable such as case management for Medicaid recipients and flex funds to help youth and young adults succeed in the program. In addition, the remaining funds will be used to pilot the modified HT site in the Central Falls/Pawtucket area.

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

We continue to utilize the local evaluation data including service delivery and outcome measures for non-discretionary grant funded sites. These data have been crosswalked with the GPRA data tool to ensure parity in data collection efforts. An internal evaluator helps coordinate the data between all four operating sites and set up a tool for the new site that should be operational as of October 2021.

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 mental illness or first episode psychosis.

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

None at this time.

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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 team 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, education, 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? (•) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

The Department has regulations to ensure that person-center planning occurs with a flexible treatment plan that is created after a biopsychosocial assessment. More details are available in question 4.

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.

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

N/A

Footnotes:

Environmental Factors and Plan

6. 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 M/SUD 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 M/SUD 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 M/SUD 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 program requirements, including quality and safety standards? (●) Yes ( ) No

3. 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. Five BHDDH staff members are currently going through the certification process to become certified grants management specialists in order to provide assistance to all contract monitors and discretionary project directors on the requirements of SAMHSA grants. This process has triggered the creation of additional policies and procedures to ensure proper grant management.

Please indicate areas of technical assistance needed related to this section

None at this time.

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Footnotes:

Environmental Factors and Plan

7. 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**[56] 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.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

We have one scheduled in late August with the Narragansett Tribe between our NTN representative and another staff member and the tribal leadership.

2. What specific concerns were raised during the consultation session(s) noted above?

This consultation is to see if we can expand SUD and MH services including naloxone education/advocacy work, and focusing on overdose prevention. The hope is to begin building this relationship.

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

Not at this time.

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

None.

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Footnotes:

Environmental Factors and Plan

8. 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:

1. ***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;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***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;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***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

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [ ] Other (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)
- [x] Youth (ages 12-17)
- [x] Young adults/college age (ages 18-26)
- [x] Adults (ages 27-54)
- [x] Older adults (age 55 and above)
- [x] Cultural/ethnic minorities
- [x] 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)

- [x] National survey on Drug Use and Health (NSDUH)
- [ ] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [ ] Communities that Care
- [x] 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 purpose of the Block Grant Needs Assessment was to help develop a data-driven plan on where to allocate Block Grant funds based off the substance abuse and mental health patterns in Rhode Island. Quantitative and qualitative data were utilized throughout the needs assessment. The Block Grant Needs Assessment sought to identify areas in which needs appeared to be adequately met and areas where services needed to be strengthened. Through these steps, BHDDH could better determine how to efficiently direct SAMHSA's funding to meet the needs of Rhode Island residents.

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

Narratve 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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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? (●) Yes ( ) No

If yes, please describe

The Rhode Island Certification Board (RICB) defines a baseline standard for all credentials offered. Certification continues to be an important component of workforce development of substance abuse prevention providers. Certification in the field of substance abuse prevention is based on knowledge in six performance domains that are 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. Current certifications offered include the APS (associate prevention specialist) which is for entry level substance abuse prevention providers, CPS (certified prevention specialist), and CPSS (certified prevention specialist). The newest certification is ACPS (advanced certified prevention specialist) which will likely replace the CPSS in the near future.

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

If yes, please describe mechanism used

The state contracts with a vendor to provide ongoing training and technical assistance. This vendor, the Rhode Island Prevention Resource Center (RIPRC) is a statewide, central information sharing, 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. It is essential that the RIPRC matches its trainings to the needs of the provider in the state. This targeted approach facilitates core competency development in the workforce, allowing providers to better serve their communities. As of January 2017, Rhode Island moved to a regional prevention service delivery model. Then needs assessment addressed needs related to the transition.

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 assistance 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: application to request funds. Our technical assistance 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 compliments the services in the RFP.

Delegated authority: The Department sought and received delegation of contracting authority in pertaining to the disbursement of grant funding to Regional Substance Abuse Prevention Task Forces for cost associated with activities or services designed to prevent substance misuse/abuse within Rhode Island's cities and towns for the period of 7/6/2018 through 1/31/23. These activities or services include assessing prevention needs and resources, building capacity to implement evidence based or evidence informed interventions and strategies, creating service delivery plans, delivering services and monitoring or evaluating the impact of activities and services provided.

Delegated authority permits the Department to award funding to all agencies classified as a regional substance abuse prevention task force by BHDDH through a funding formula based on a per capita basis or rates of consumption, for example, a formula funding based on high need as described by high levels of negative consequences associated with substance use/misuse (such as rates of opioid overdose within the region) or high rates of substance misuse or use.

The delegated authority is derived from Rhode Island General Law 16-21.2 which establishes substance abuse prevention programs and establishes BHDDH as the vehicle to administer funding. Rhode Island General Law 40.1-1-13 defines the powers and duties of BHDDH in developing, providing for and coordinating the implementation of a comprehensive state plan for substance abuse education, prevention and treatment. Furthermore, Rhode Island General Law 40.1-1-13 (8) specifically empowers the BHDDH to act in the capacity of the Substance Abuse and Mental Health Authority. The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals is the federally authorized co-Single State Agency for Substance Abuse Services.

This designation allows the Department the unique capacity to understand the clinical and environmental needs of the community and ensure access to the opportunity to administer federal funding both through the federal block grants and competitive discretionary grants.

Narratve 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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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

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 prevention funds? (●) Yes ( ) No

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 the 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 Rhode Island. An Evidence Based 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 to expand its's 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 quarterly since October of 2014 and will continue to do so under the new SAMHSA'S Partnership for Success Initiative awarded in the fall of 2018.

Narratve Question

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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 statewide 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. Several 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. They have also implemented Change Direction campaigns to encourage individuals to look for signs of depression and suicidality in their peers and community members. The political landscape in Rhode Island has shifted to consider legalization of recreational use of marijuana as early as 2021. Information on the harmful effects of marijuana are distributed across the state through the regional prevention task forces. Underage drinking continues to be a high levels. and we saw an increase in this with both adults and younger people due to COVID- 19. RPTF coalitions got creative by contacting alcohol retailers and providing the best practices on performing identification checks, responsible beverage sever training, regulate home delivery and internet sales, display signage deterring underage serving and purchase, utilize sticker shock

campaigns. The coalitions worked with local restaurants to include messaging on take out menus and napkins. RPTF coalitions distributed information in different ways then normal due to COVID-19 by using food pantries, local police departments and school lunch/breakfast programs. The Drug Take Back initiative was performed in a different way by distributing lock bags, mailers, Deterra, DisposeRx through local pharmacies, food pantries, and senior centers. There was much success in these new ways of doing business with some practices planning to continue beyond the pandemic.

b) Education:

RPTF coalitions fund 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 Strategic Prevention Framework Partnership for Success 2013 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. New evidence based programs more recently implemented include: Strengthening Families, Familias Unidas, Project Alert, and Delta 9. Due to COVID-19 RPTF coalitions had to make modifications to accessing students through online platforms as most were doing remote learning.

Our student assistance program provides PROJECT SUCCESS' Prevention Education Series, an alcohol, Tobacco and Other Drug prevention program conducted by a Master's Level Student Assistance Counselor (SAC) with small groups of students in over 40 Rhode Island middle and high schools. This was done online during COVID-19 through google classroom and other platforms during remote learning. There was much success in these new ways of doing business with some practices planning to continue beyond the pandemic.

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. 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. Due to the COVID-19 Pandemic most of these events were postponed, held virtually or new formats were offered to our young people to engage them such as podcasts and online formats. There was much success in these new ways of doing business with some practices planning to continue beyond the pandemic.

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
- 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- Project SUCCESS counselors complete a screening to identify the primary reason for referral. Students that have used or misused substances are provided education to address the behavior and to prevent further use. If this education is ineffective and the behavior is not reversed the student will be referred to appropriate agencies or practitioners in the community. This represents approximately one third (1/3) of students served and ranges between 3,500 and 4,000 students annually. The state does not plan to expend SABG primary prevention funds to any activity designed to determine if a person is in need of treatment or any activity other than primary prevention of substance abuse. The Student Assistance program is only partially funded by SABG and those funds are used for primary prevention only.
- School-wide Awareness Activities- conducted monthly with student participation to influence attitudes and norms about substances and related high risk behaviors.
- 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- Project SUCCESS counselors complete a screening to identify the primary reason for referral. Students that have used or misused substances are provided education to address the behavior and to prevent further use. If this education is ineffective and the behavior is not reversed the student will be referred to appropriate agencies or practitioners in the community. This represents approximately one third (1/3) of students served and ranges between 3,500 and 4,000 students annually. The state does not plan to expend SABG primary prevention funds to any activity designed to determine if a person needs treatment or any activity other than primary prevention of substance abuse. The Student Assistance program is only partially funded by SABG and those funds are used for primary prevention only. - School-wide Awareness Activities- conducted monthly with student participation to influence attitudes and norms about substances and related high risk behaviors.
Under the recent SOR grant, an opioid module will be added to the Prevention Education Series at all schools and an additional eight schools will receive Student Assistance Services, bringing the total to around 50 middle and high schools receiving Student Assistance Services.
SACs performed their work differently during COVID-19: coordination of direct services to students with district Pupil Personnel Staff (PPS) and school administration including emergency protocols (e.g. suicidal risk, DCYF reporting); coordination with administration on where and how connections to students will be made.; some schools allowed their PPS staff including the SAC to have “office hours” where they can schedule telephone check-ins with students; email outreach by SACs to students; SACs sending resources home to students and families in coordination with what schools sent home; and sent a parent letter home letting parents know if they are concerned about a student, they can contact the SAC via a phone number provided. here was much success in these new ways of doing business with some practices planning to continue beyond the pandemic.

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

Meetings and engagement occurred virtually due to COVID-19. There were more participants. As we open up and move to face to face meetings it is likely that RPTF coalitions will offer continue to offer the option to attend virtually as well as in person.

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.
RPTF coalitions assist in the collaboration of municipal police departments as well as the recruitment of underage inspectors for both the Synar tobacco inspections. The state does not plan to expend SABG primary prevention funds for law enforcement apart from paying for law enforcement officers' time during Synar youth tobacco access inspections.
Under Strategic Prevention Framework Partnerships for Success 2018 program goals, a minimum of one environmental strategy will be required for every one of the 20 high-need communities.

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. Contract monitors go through monthly invoices to ensure that dollars are spent on allowable costs and use the Mosaix IMPACT(c) data system to look at activities to ensure they are within the scope of their contracted work.

Narratve 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:

1. ***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;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***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;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***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

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

Strategic Plan for

Substance Misuse Prevention

2020-2024

SECTION 1 - INTRODUCTION

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

Mission and Vision

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

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

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

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

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

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

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

Planning and Conceptual Framework

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

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

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

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

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

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

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

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

SECTION 2- RHODE ISLAND BHDDH PREVENTION INFRASTRUCTURE OVERVIEW

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

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

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

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

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

Rhode Island Substance Abuse Prevention Act (RISAPA) - In 1987, the Rhode Island General Assembly passed the Rhode Island Substance Abuse Prevention Act (RISAPA) to promote comprehensive prevention programming at the community level. In 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).

The RPTF also address underage tobacco misuse by educating community leaders, advocating for local policies/ordinances related to point of sale (POS) purchase restrictions, creating smoke free policies and by providing comprehensive merchant education. RPTF coalition also provide education to retail tobacco licensees within their region on federal and RI law relating to the sale or distribution of tobacco products

Over five years the RPTF will use funding to assess our community substance misuse prevention needs and resources, developed a capacity building plan to address any gaps in resources or community readiness and a local strategic plan, implemented evidence based and best practice interventions based on community needs, and evaluated the impact of our efforts.

Synar- BHDDH is the designated state agency responsible for ensuring compliance with the federal Synar Amendment which requires all states receiving SAPT Block Grant funding to have in place and enforce a state statute prohibiting the sale or distribution of tobacco products to individuals under the age of eighteen; to conduct an annual statewide survey of retail tobacco outlets to determine retailer compliance with the state statute; to report the results of the Annual Synar Survey in the Annual Synar Report; and to maintain a statewide retailer violation rate under 20% as a condition for receipt of SAPT Block Grant funding. Included in the Report is a detailed description of prevention efforts conducted by

the prevention coalitions to reduce youth access to tobacco. Since 1998, consistent with state law (RIGL- 11-9-13) inspection and enforcement provisions, BHDDH has contracted with municipal police departments to assist in the Annual Synar Survey and to engage in ongoing enforcement of the State's youth access to tobacco statute.

Collaborating BHDDH Grants/Cooperative Agreements

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

Healthy Transitions (HT): Healthy Transitions RI is in the process of completing the objectives of its grant, set to close on September 30, 2019. The grant addressed the needs of 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.

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

Partnerships for Success (PFS): The Strategic Prevention Framework-Partnerships for Success II grant (PFS II) will address one of the nation's top substance misuse priorities; underage drinking among persons aged 12-20. The purpose of the grant is to prevent the onset and reduce the progression of substance misuse and its correlated problems while strengthening prevention capacity and infrastructure at the state and community level and ensuring that prevention strategies and messages reach the identified target population. PFS II provides funding to 20 communities that have been identified as highneed based on a selected set of indicators. The identified communities are Burrillville, Bristol, Central Falls, Charlestown, Cranston, East Greenwich, East Providence, Hopkinton, Johnston, Lincoln, Middletown, Narragansett, Newport, North Kingstown, North Providence, Portsmouth, Richmond, Warren, Warwick, Woonsocket. The communities will implement a set of comprehensive, evidence-

based practices and policies to address the priority problem. The anticipated total reach is 56,479 individuals ages 12-20.

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

State Opioid Response (SOR): The Rhode Island State Opioid Response (RI-SOR) grant is designed to 1) reduce the number of prescription drug/opioid overdose-related deaths and adverse events among individuals 18 years of age and older, 2) increase access to treatment and reduce unmet needs through the provision of prevention, treatment, and recovery activities, and 3) support a comprehensive response using epidemiological data in the planning process. Data collected via the GPRA and other internal measures will help identify any gaps in the continuum of care and inform future expansion and evolution of these activities. The overarching goals of these initiatives are: 1) to increase access to medication assisted treatment, 2) increase access to treatment and recovery support services in the community, and 3) increase the capacity of the community to assess, plan, and implement strategies to prevent substance/opioid misuse.

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.

Internal and Interagency Planning and Advisory Groups

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

Prevention Advisory Committee- The PAC is a committee of the Governor's Council on Behavioral Health. The PAC provides recommendations to the Governor's Council which 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 misuse prevention efforts, integrate partnerships in prevention; reach populations that have been hard to reach; integrate systems for better evaluation and data collection; define prevention within the Affordable Care Act (ACA); work to eliminate health disparities and stigma around mental health and substance use disorders; and coordinate efforts across state departments

and community providers. The PAC is committed to strengthening and expanding the prevention workforce in Rhode Island.

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

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

Training, Technical Assistance and Workforce Development Partners

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

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

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

Evaluation Partners

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

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

- Assessing the efficacy of the Regional Task Force coalition model
- Determining fidelity in the Regional model
- Completion rates for the biannual RI Student Survey
- Effectiveness of Regional Task Force coalition in achieving capacity/infrastructural outcomes
- Effectiveness of the specific evidence-based practices implemented and their impact on achieving behavioral outcomes
- Effectiveness in accomplishing key sustainability tasks
- Student Assistance evaluation
- RI Prevention Resource Center evaluation

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

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

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

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

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

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

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

Please consult the full 2019 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 2020-2024 Strategic Plan for Substance Misuse Prevention

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

A. Diagnosis of substance use disorder as defined by the American Psychiatric Association's Diagnostic and Statistical Manual diagnosis of illicit drug substance use disorder

B. Diagnosis of substance use disorder as defined by the American Psychiatric Association's Diagnostic and Statistical Manual diagnoses of alcohol substance use disorder

C. Drug overdose, especially those attributed to opioids and prescription drugs

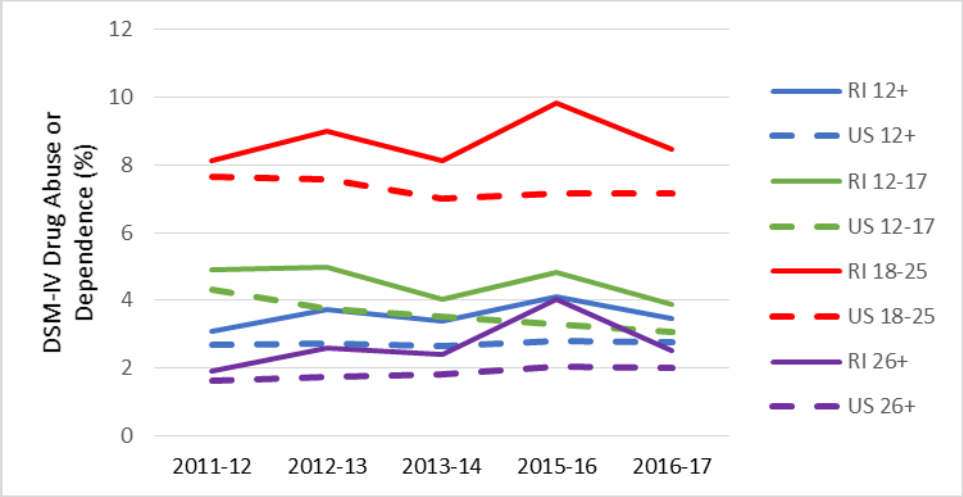
   OBJECTIVE: The BHDDH 2020-2024 Strategic Plan contains the following objective related to overdose prevention: By December 2022, 100% of RI communities will sustain at least one activity promoting safer disposal practice previously funded by discretionary grants (Count It, Lock It, Drop It media campaign: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

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

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

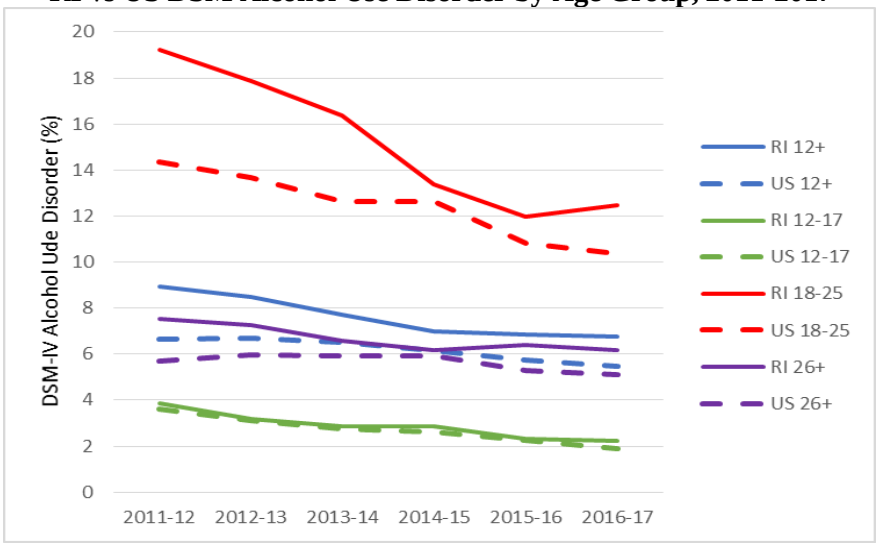
While diagnosis of substance use disorder as defined by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) diagnoses of substance use disorder are potentially changeable with primary prevention strategies, it will take considerably longer than the time frame covered in this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

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



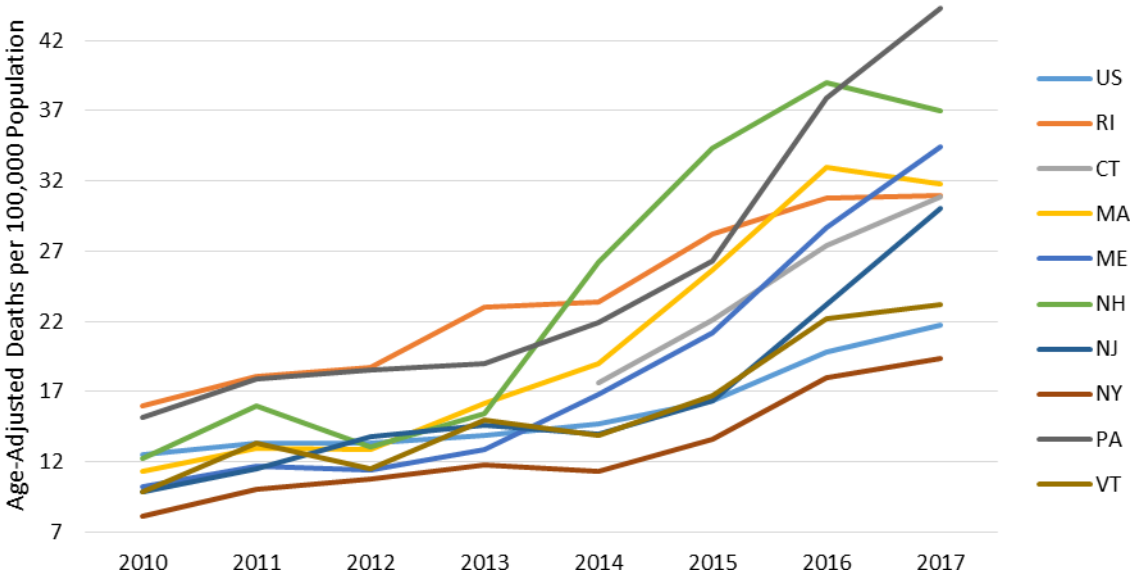
Source: National Survey on Drug Use and Health (NSDUH). **Note:** No data available for 2014-2015.

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



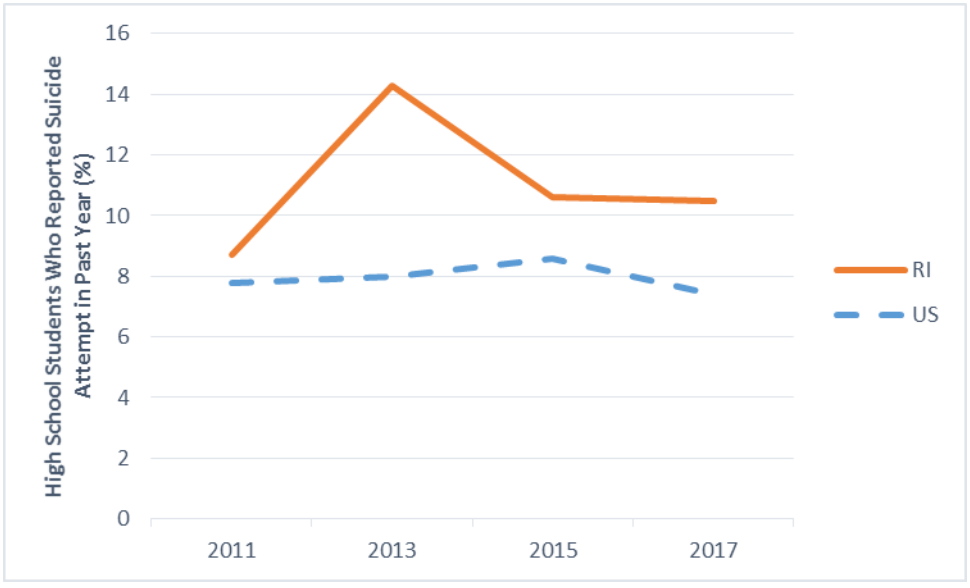
Source: National Survey on Drug Use and Health (NSDUH). ***Note:*** *Indicator name changed from Alcohol Abuse or Dependence to Alcohol Use Disorder in 2014-15.*

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



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

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



Source: Youth Risk Behavior Survey, Centers for Disease Control

Lastly, the percentage of youth who reported attempting suicide as compared to US percentages overall is slightly elevated[1]. This selection of priority consequence is based on the ability to reduce suicide attempts by addressing shared risk and protective factors between substance misuse and suicide.

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

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

A. Use of marijuana 12-17

B. Use of marijuana 18-20

C. Problematic patter of use of marijuana 21-25

D. Use of illicit drugs other than marijuana 12-17

E. Use of illicit drugs other than marijuana 18-20

F. Use of illicit drugs other than marijuana 21-25

G. Underage drinking 12-17

H. Underage drinking 18-20

I. Binge drinking 21-25

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

Marijuana Use

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

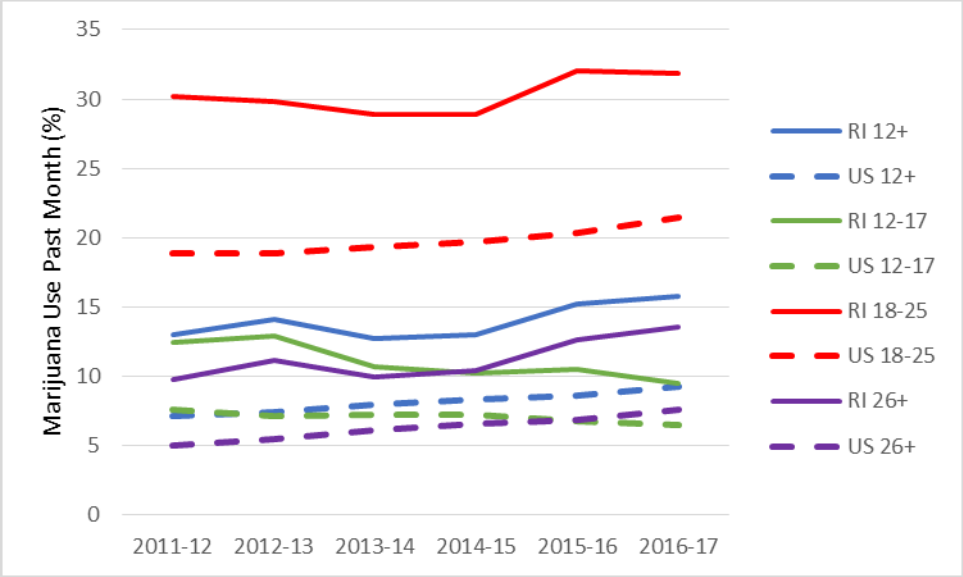
[1] Please note that the 2013 percentages reported in the chart above are believed to be an anomaly based on the RI Department of Health's review of other data for the same time frame

Strategies to support this objective are: (1) provide funding to Regional Prevention Task Forces to use information dissemination strategies to increase perception of risk of harm associated with marijuana use among adolescents ages12-17 and their families; (2) provide funding to implement Project SUCCESS' to implement (a) the Prevention Education Series as a grade wide intervention to 7th and 9th graders, and (b) to support problem identification and referral of in 31 RI school districts (both are components of Project SUCCESS).

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

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

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

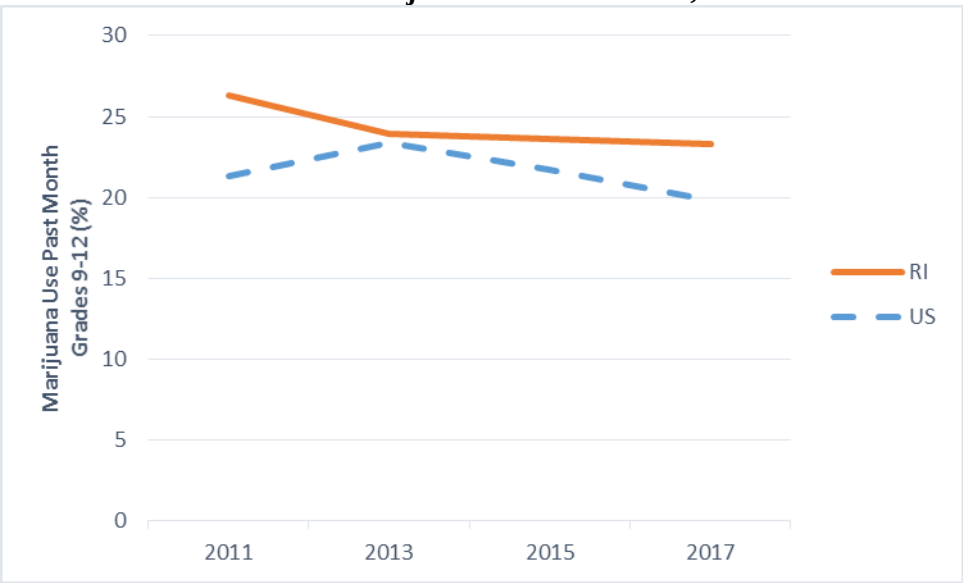


Source: National Survey on Drug Use and Health (NSDUH)

Primary prevention efforts to reduce marijuana use among adolescents may also produce beneficial effects among young adults over the long term as initiation primarily occurs prior to the age of 18. Various BHDDH managed funding streams have been targeting youth marijuana use since 2010 and as the chart above indicates,

Marijuana use among 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, 2011-2017



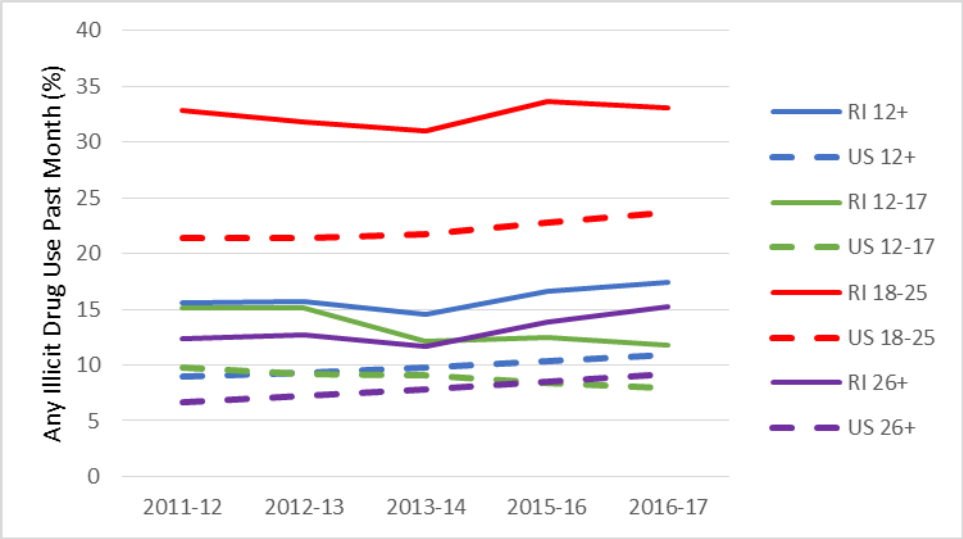
Source: Youth Risk Behavior Survey, Centers for Disease Control

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

Illicit Drug Use

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

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



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

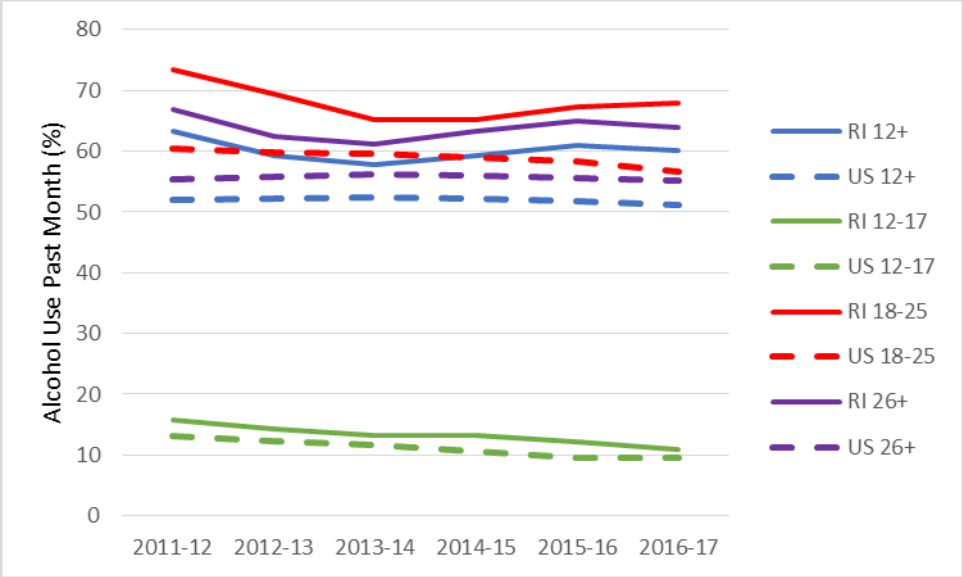
Underage Drinking and Past 30-Day Use Among Young Adults 18-25

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

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

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

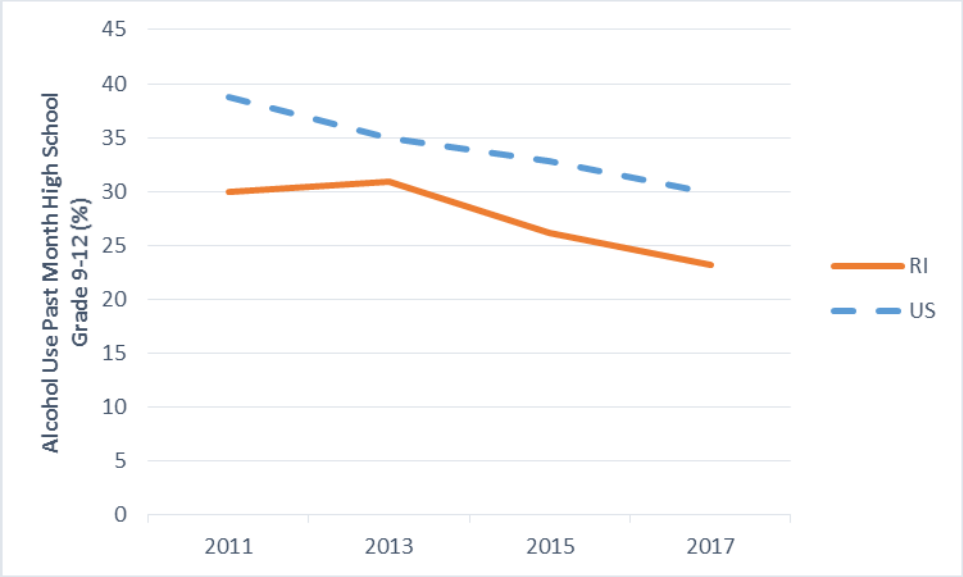
Alcohol Use Past Month by Age Group, 2011-2017



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

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

Youth Alcohol Use Grades 9-12, 2011-2017



Source: Youth Risk Behavior Survey, Centers for Disease Control

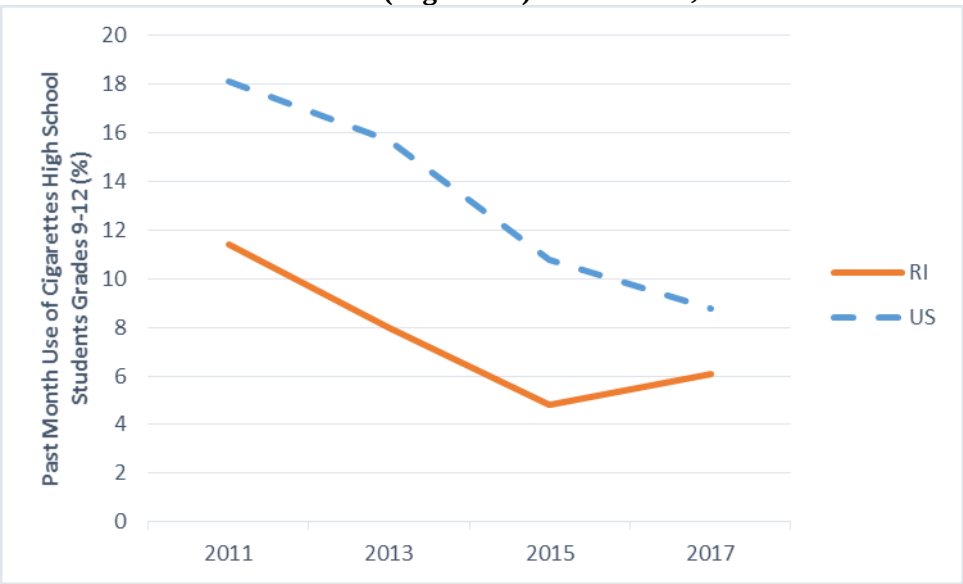
Youth Tobacco Use

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

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

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

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



Source: Youth Risk Behavior Survey, Centers for Disease Control

C. RISK & PROTECTIVE FACTORS

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

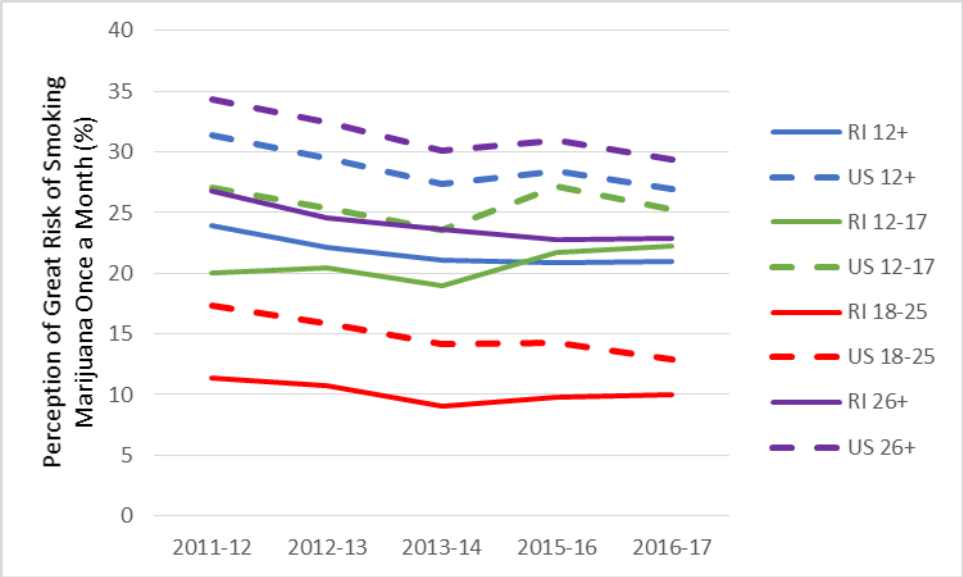
BHDDH provides funds through the Substance Abuse Prevention and Treatment Block Grant to RI communities to implement strategies to address these risk and protective factors. In addition, twenty Rhode Island communities are currently receiving funding through the Partnerships for Success II (PFS II) grant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

1. Priority Risk or Protective Factors

2. Perception of risk or harm

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

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



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

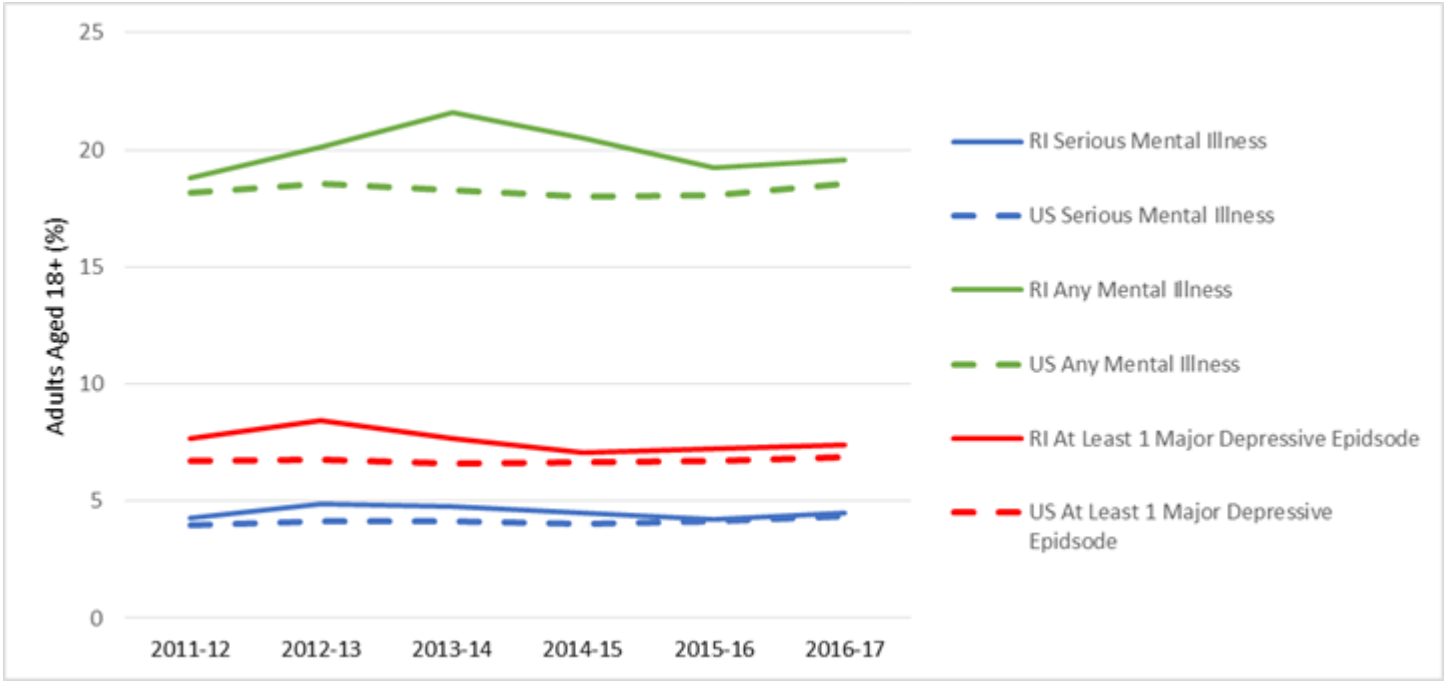
3. Access and Availability of Substances with Age Based or Other Conditional Use Restrictions

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

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

D. MENTAL HEALTH

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



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

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

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

Efforts to include mental health promotion in the work of prevention coalitions 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 2017State 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.

SAMHA's Strategic Plan FY2019-FY2023
Priorities and goals related to prevention:

Priority 1: Combating the Opioid Crisis through the Expansion of Prevention, Treatment, and Recovery Support Services
Goal
Reduce opioid misuse, use disorder, overdose, and related health consequences, through the implementation of high quality, evidence-based prevention, treatment, and recovery support services

Priority 3: Advancing Prevention, Treatment, and Recovery Support Services for Substance Use
Goal
Reduce the use of tobacco (encompassing the full range of tobacco products and reduce the misuse of alcohol, the use of illicit drugs, and the misuse of over the counter and prescription medications and their effects on the health and well-being of Americans.

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

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

SECTION 5 - STRATEGIC PLANNING GOALS AND OBJECTIVES

These strategic planning goals and objectives were developed based on input from the Prevention Advisory Committee (PAC), current 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. In 2018 the PAC performed a Strength, Weakness, Opportunities and Threats (SWOT) analysis and provided this feedback to BHDDH. The goals and objectives, provided below, prioritize infrastructure development, workforce development and reduction of key risk factors identified in the state's EPI profile. BHDDH's prevention goals are designed to foster and monitor the supports, collaborations, and systems needed to meet the desired outcomes related to reducing risk factors and promoting protective factors.

A. SYSTEM-LEVEL INFRASTRUCTURE DEVELOPMENT:

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

Objective I: Ongoing after July 1st and through option years 2018-2020 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 prevention providers' ability to integrate substance use prevention and mental health promotion across behavioral health provider systems.*

Objective I: By Dec 31, 2020 (and for each year after) RIPRC will document the surveillance of current providers for prevention and mental health promotion on the state and community level(s) to ensure contract deliverables are being met and document the integration of behavioral health across prevention initiatives through the production of an annual summary report presented to the PAC and to the Governor's Council on Behavioral Health. The summary report will document the integration of mental health promotion in substance use prevention initiatives across the following state and community level organizations:

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

Objective II: Groups addressing behavioral health issues will maintain meeting schedules and provide meeting feedback to the Prevention Advisory Committee. Each meeting will specifically identify opportunities to address the following: 1) to increase communication across the sectors; 2) to identify increased opportunities for collaboration across sectors; 3) to ensure promotion of existing prevention

services and initiatives and; 4) to document the integration of prevention and mental health promotion across behavioral health provider systems.

Meetings will include and meet as follows:

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

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

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

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

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

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

1) BHDDH Prevention and Planning Unit*
2) Department of Health (HEALTH) and/or Community Violence Prevention and/or Suicide Prevention*
3) RI Substance Abuse Prevention Act (RISAPA)* – *Regional Prevention Task Force Coalitions*
4) Certified Prevention Specialist*
5) Student Assistance Program*

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

Please note sectors followed by an 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); 4) disseminate quarterly meeting notes and action items; 5) identify priority prevention areas; 6) disseminate information to key stakeholders; 7) submit recommendations regarding prevention priorities and policies to Governor's Council on Behavioral Healthcare.

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

Goal Four: *Develop and document a plan to improve state and local cross organizational collaboration among funded providers who implement prevention initiatives. The plan will be designed to document the improvement of local, regional and/or state infrastructures to provide effective and inclusive behavioral health services. Elizabeth Farrar will be responsible for developing this plan with assistance from the Governor's Overdose Task Force Prevention Strategy Workgroup.*

Objective I: By July 31, 2020, develop and implement a state-wide inventory of behavioral health prevention services, regardless of funding source.

Objective II: By July 31, 2021, develop and implement a state-wide inventory of data collected which may inform prevention efforts, regardless of funding source.

B. WORKFORCE DEVELOPMENT AND SUSTAINABILITY:

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

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

The following list outlines the classification levels for prevention providers:

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

Objective II: By July 31, 2020, 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, 2019 (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, 2023 (and every year after), BHDDH will develop and/or update a sustainability plan to specifically outline prevention and mental health promotion programming, policies and initiatives or recommendations.

Objective III: By July 31, 2024, sustain and update a suite of training and performance monitoring tools to guide on-going prevention program improvement.

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

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

Having a greater number of CPS will help to meet workforce development goals to increase the capacity, knowledge, skills and organizational development of prevention and mental health

promotion providers to address complex substance use problems and consequences, as well as self-harming and adverse behavioral health consequences.

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

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

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

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

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

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

- Business*
- Education*
- Safety*
- Medical/health*
- Government*
- Community/family supports*
- Youth
- Parent
- Media
- Youth-Serving Organization
- Religious/Fraternal Organizations

- Other Substance Misuse Organizations

* Sectors marked with an asterisk are contractually required.

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

Objective V: After January 1, 2020, funded providers will address a minimum of one of the following priorities based on the results of the municipality's needs assessment and regional strategic plan:

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

a. Use of marijuana 12-17

b. Use of marijuana 18-20

c. Problematic patter of use of marijuana 21-25

d. Use of illicit drugs other than marijuana 12-17

e. Use of illicit drugs other than marijuana 18-20

f. Use of illicit drugs other than marijuana 21-25

g. Underage drinking 12-17

h. Underage drinking 18-20

i. Binge drinking 21-25

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

Objective VI: The Rhode Island Student Survey (RISS) is a risk and prevalence survey for youth in middle and high school. A risk and prevalence survey looks at set of factors or conditions to which youth may be exposed that are associated with negative behavioral health outcomes and the extent to which youth may report engaging in problem behavior. It explores substance use, bullying, depression, suicide and violence. The RISS has been administered in 31 school districts throughout Rhode Island. The RISS currently has sixty -two questions. There is no personally identifiable information associated with the RISS. The questions are arranged in a particular way and explore specific topic areas. To youth, in particular, it may seem like they are repetitive, but the questions actually probe different components or dimensions of the situation. For example, questions are asked about multiple substances of abuse such as alcohol, tobacco, marijuana, illicit and prescription drugs. The questions are also asked across several domains such as the individual him/herself, peers, family, school and community. For example, students are asked about their perception of risk or harm associated with levels of use for each substance. Students are also asked about their individual perceptions of wrongfulness of use, as well as their perception of disapproval of use by peers and parents. The questions are asked across each substance

because, for example, low perception of risk by the individual and low disapproval of use of marijuana among peers and parents has been linked in research to a greater likelihood of youth marijuana use. The intention and purpose of the RISS is to identify areas where there are strengths that can be built upon and to put additional resources to those areas that need improvement. The data is reviewed in aggregate, not at the individual level. The data is not meant to identify individuals. There are other surveys administered in schools, but most do NOT allow for the ability to analyze data at the school district or community level. This data is crucial for planning prevention services especially when resources are so scarce.

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

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

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

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

Objective I: Between January 1st, 2018 and December 31st, 2024, funded entities should increase the perception of risk of harm associated with the chosen priority substance by 10% among the target population.

Objective II. Between January 1st, 2018 and December 31st, 2024, funded entities should reduce the access or perceived ease of access among populations for whom possession, use or consumption is illegal by 10% among the target population.

OBJECTIVES	STRATEGIES	MEASURES
• By September 2024 reduce prevalence of underage alcohol use by 3% over 2016 baseline. • By September 2024 maintain or reduce marijuana use by 12-17 at 2016 baseline rates	(1) provide funding to Regional Prevention Task Forces to use information dissemination strategies to increase risk of harm associated underage drinking among adolescents ages 12-17 and their families; (2) implement Project SUCCESS' Prevention Education Series as a grade wide intervention to 7th and 9th graders; and (b) to support problem identification and referral as part of Project SUCCESS in 31 RI school districts; and (3) use funding from the Partnership for Success 2018 award to implement (a) educational strategies in school settings (middle school/junior high school, high schools and colleges/universities); (b) implement environmental strategies addressing social and retail access; and, (c) implement workplace interventions aimed at employers of 18-20 year-olds. 3) provide funding to Regional Prevention Task Forces to use environmental change strategies to restrict alcohol access for youth (1) provide funding to Regional Prevention Task Forces to use information dissemination strategies to increase risk of harm associated marijuana use among adolescents ages 12-17 and their families; (2) provide funding to implement Project SUCCESS' to implement (a) the Prevention Education Series as a grade wide intervention to 7th and 9th graders, and (b) to support problem identification and referral of in 31 RI school districts (both are components of Project SUCCESS). 3) provide funding to Regional Prevention Task	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: RI Student Survey) # 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)

	Forces to use environmental change strategies to restrict marijuana access for youth	
• By December of 2024, the illegal tobacco sales violation rate for <18 will be maintained at or below 20% based on vendor education, point of sale ordinance or policy implementation increased compliance checks.	i. (1) provide funds to 7 Regional Prevention coalitions to implement either vendor education or point of sale ordinance or policies in RI cities and towns; and (2) conduct compliance checks and enforcement activities to insure that state laws prohibiting sales of tobacco products (conducted as part of the annual Synar survey) and select communities implement additional compliance checks; and (3) conduct compliance checks and other enforcement activities to ensure that Federal laws prohibiting sales of tobacco products are enforced (conducted as part of the Department's FDA contract).	% of tobacco retailers that sell tobacco to minors (Source- Synar Survey) # compliance checks # individuals trained
• By 2019, reduce opioid and prescription overdose deaths as well as deaths related to the nonmedical use of prescription drugs by 1/3, from 290 in 2015 to 159. • By 2018, increase the percentage of prevention coalitions implementing overdose prevention activities	i. (1) Increase the number of municipalities participating in drug take back days (expand to Scituate, North Smithfield and Exeter); (2) Increase the number of permanent drug disposal sites (expand to Scituate, North Smithfield and Exeter); and (3) Sustain the number of Regions implementing the Count It, Lock It, Drop It awareness campaign.	# of overdose deaths (Source: Medical Examiner, RI DOH) # individuals trained # individuals exposed to messages # events

SECTION 6 - SUMMARY and CONCLUSION

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

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

Process and Outcome Evaluation of Services Provided by Regional Cooperative Agreement
7/1/2021-6/30/2022

The Community Research and Services Team (CRST) will provide process and outcome evaluation services related to the substance abuse prevention services other specified services in accordance with the responses of entities who received awards under **RFP#7550738 Regional Prevention Task Forces (including associated addenda; Addendum 1 posted 7/12/2016 and Addendum 2 posted 7/25/2016), and also RFP#7574929 Rhode Island Student Assistance Services (including associated Addendum 1 posted 2/12/2015).**

The CRST at the University of Rhode Island will conduct the evaluation. The CRST has demonstrated a long history of completing quality program evaluations at the state and local levels. In addition, the lead investigators of the CRST have multiple advanced degrees in clinical psychology, as well as in statistics, and are well versed in the most current evidence-based practices and policies regarding prevention of substance misuse and mental health promotion.

A. SCOPE OF WORK – SPECIFIC TASKS

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 and compare this with any changes that may occur at years 2, 3, 4 and 5 of the projects. 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. During year four and into year five, this data has been enhanced in several powerful ways, described in the next paragraph.

First, during February and March 2021, the CRST added one hour key informant interviews with each of the RPTF regional directors. These key informant interviews were designed in order to better understand the unique contextual conditions that impacted each region. More specifically, they asked the RPTF directors to distinguish "members" from "partners", organizations whose representatives do not regularly attend RPTF coalition meetings but which still make significant contributions to the mission of the RPTF. In addition, they allowed the regions to "tell the story" of how each met BHDD's original RFP's intent of expanding the scope of prevention populations, integrating mental health and substance abuse prevention and expanding behavioral healthcare (e.g., both mental and substance abuse prevention) into the existing physical health care delivery system. The key informant interviews will be used to identify those organizational "partners" in each region to whom a PARTNER survey will be sent in May and June 2021.

The Regional Coalition Member Survey will be administered for the final time during year five in August and September 2021 to provide perspective including changes over time.

All the data sources will be carefully analyzed and "crossed referenced" during the next several months of year 5 (October 2021 through January 2022). Both qualitative and quantitative (especially visualization of "network maps") will be developed during this time period.

February through March 2022 of year five will be used to draft the network section of the first draft of the final report. The final report will help answer the following questions: 1) has network membership across sectors grown and expanded over time; 2) did the proportion of members who are active in the network grow; 3) did members both bond and bridge in the network; 4) what does the relative proportion of "members" to "partners" look like in each of the networks and finally 5) within each network what are

some exemplar "expansion" innovations that involved members and partners (i) extending the scope of prevention populations, (ii) integrating mental health and substance abuse prevention and expanding behavioral healthcare (e.g., both mental and substance abuse prevention) and (iii) into the existing physical health care delivery system. Since each RPTF region has a unique configuration, members / partners and prevention emphases, the CRST expects that each region will read like a "case study In May the CRST will edit the "case study" reports and BHDDH will review the summary report. Final edits to all will be made in June 2022 and turned into BHDDH.

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 the level of trust among members in the network is; and 3) what the power relationships within the network are 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 biennial RISS administration (from RI Student Survey Dashboard as described in Appendix I).*

Completion rates for biennial 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, as well as fidelity instruments from Project Success.

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 from the Project Success curriculum 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 the Prevention Education Series. Data will be aggregated at a municipal and regional level, and will be reported to the funder annually, when possible. Data regarding the number of groups held in each school, number of assessment and referrals, number of school-wide activities, and number of parent-focused programs/activities will be obtained from the Mosaix IMPACT system and reported to the funder annually. In 2021 the CRST added a way for Student Assistance Counselors to indicate whether the Prevention Education Series (PES) of Project Success was delivered in person or remotely. The final report to be turned into BHDDH in June 2022 will include a summary table of which classrooms in which schools successfully met fidelity criteria for the PES and which did not.

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. Given that the RISS will be administered in the 2017-2018 and 2019-2020, and 2021-2022 school years, data from the 2018 administration of the RISS will serve as a baseline for selected risk and protective factors (peer disapproval of ATOD use). Where applicable (i.e. when response rates exceed 60% by grade level administration of the RISS), comparisons in prevalence and select risk and protective factors will be made across time. The ability to conduct such comparisons for the final RPTF report will obviously depend upon the results of the RISS and where it was able to meet the 60% criteria by which grade.

3. Rhode Island Prevention Resources Center (RIPRC)

The CRST will continue to conduct a process evaluation of completed activities and reach for the RIPRC. The CRST assisted the RIPRC with developing a data collection tool for use on their website in order to capture *who* is utilizing the RIPRC, and for *what* purpose. The CRST also developed a survey to administer to individuals and organizations who have utilized the RIPRC for TA and training purposes. Additional survey items were developed for inclusion on existing pre- and post-intervention (workshop/training) measures, and a follow-up survey was developed, administered, and maintained by the CRST throughout the life of the project. This survey was administered to individuals and/or organizations that utilized services through the RIPRC, in an effort to better understand whether specific behavioral objectives identified at pre-and (immediate) post-intervention (workshops/training) s were implemented over a pre-specified course of time. The CRST worked collaboratively with the RIPRC to develop these measures and provide timely feedback.

4. Rhode Island Student Survey (RISS) coordination and technical/analytic consultation.

The evaluation plan for the Regional Prevention Task Forces and Student Assistance/Project SUCCESS relies on several items from the RISS. The RISS contractor is responsible for survey administration, data cleaning and preliminary analysis of RISS items. CPRC is responsible for outcome analysis including temporal trends and selected multi-variate analyses. Given the multiple contractors involved and the importance of the RISS to program evaluation across the various primary prevention programs funded by BHDDH and evaluated under the terms of this cooperative agreement, coordination is critical. To that end, CRST will:

1. Attend bi monthly meetings convened by BHDDH between CPRC, the RISS contractor, the Epidemiology Support contractor, other relevant parties and BHDDH, which will include one meeting per quarter with sub-recipients (RPTFs, Student Assistance and other relevant discretionary grants).
2. Meet with the RISS contractor as needed or at the request of BHDDH.
3. Provide technical/analytic consultation to the RISS contractor on the following:
    a. Projection of the target number of students necessary per grade to meet the 60% threshold for completion rates based on the RI Department of Education school grade-level enrollment data from the prior academic year.
    b. Establish a protocol for harmonization of RISS data presentation for any output provided to sub-recipients.

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 computers 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, and the RIPRC. 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.

C. DELIVERABLES AND REPORTS

1. A draft evaluation plan for both the RPTF, Project SUCCESS, and the RIPRC components as described in the Section A- Scope of Work, with a task and timeline, due by February 1, 2020 for year 2.

2. A final version within 30 days after BHDDH's feedback is received.

3. An annual evaluation plan documenting a timeline for completion of tasks as described in the Scope of Work, with a task and timeline. Due on or before April 1, 2020 for the 2nd year, and by June 1st for the remaining years of the award.

4. Quarterly narrative reports that describe progress on the key tasks described in the annual evaluation plan. Due by January 31st, April 30th, June 30th, and October 31st each year of the award, from 2019-2021.

5. Annual evaluation summary report with key findings. Due by August 30th of each year of the award. Key findings are to be presented at the September meeting of the Governor's Council Meeting.

6. Final cumulative close out evaluation summary report covering content key outcomes and finding related to the tasks in the Scope of Work and recommendations for BHDDH and the Governor's Council on Behavioral Health related to the effectiveness of the state's prevention infrastructure, interventions funded and future direction. Due by June 30, 2022.

D. FINANCIAL TERMS AND CONDITIONS

1. Monthly invoicing in a format provided by the Department
    a. Invoice, Attestation of Submitted Costs, and back up documentation

2. Quarterly Payroll Reconciliation sheet submission

Financial documentation will be provided by the University of Rhode Island.

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for 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-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

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 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 provides clients with access to 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.

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 MHOs 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.

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.

Mental Health Psychiatric Rehabilitative Residences, also known as residential services, 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. They 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.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

ACT Teams: Services coordinated via case management include 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.

3. Describe your state's case management services

The Rhode Island Integrated Health Homes (IHH) and Assertive Community Treatment (ACT) teams provide case management services as part of their person-centered care approach. Assertive Community Teams (ACT) includes a multidisciplinary staff to provide these support services to those who meet specific diagnostic and functional criteria assessed through the DLA tool. 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).

4. Describe activities intended to reduce hospitalizations and hospital stays.

BH Link is a program to support individuals in crisis for behavioral health issues through telephone hotlines, mobile outreach and a dedicated behavioral-health, community-based facility that provides a short-term alternative to emergency department triage that links people to treatment in the community. The triage center is located in East Providence, RI and opened in November 2018. It was highly promoted as a resource by the Governor's office as a resource during the COVID-19 pandemic.

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.

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 Homes (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 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 provides clients with access to 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.

As a state, we are beginning to explore moving towards CCBHC through the use of COVID-19 and ARPA supplemental MHBG dollars. The hope is to assess each CMHC individually and to use the funds to execute an individual-based improvement plan to meet all critieria.

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 M/SUD 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	5.4%	37,000
2.Children with SED	11%	

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.
(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.
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:
URS Table 1: Number of Adults with Serious Mental Illness, age 18 and older, 2016 (prevalence) 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. 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.
URS Table 1: Number of Children with Serious Emotional Disturbances, age 9 to 17, 2016 (prevalence). This is an external data source. Rhode Island's Departments of Behavioral Health and Children, Youth and Families do not collect data on the incidence of SED in children aged 9 to 17. The source for the statewide incidence data for adults with SMI is the 2014-2015 NSDUH state estimates.

According to the 2021 Rhode Island Kids Count Factbook-- In State Fiscal Year (SFY) 2020, 26% (30,788) of children under age 19 enrolled in Medicaid/Rite Care had a mental health diagnosis. Of the children with mental health diagnosis 23% were ages 6 and under, 37% were ages seven to 12, and 40% were ages 13 to 18. In addition, 43% were females and 57% were males.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDE	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(•) Yes ( ) 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

a. Describe your state's targeted services to rural population.

Our BH Link program has the ability to provide mobile services for clients in rural communities and with limited transportation. CMHCs has responsibilities for catchment areas that cover 100% of Rhode Island. Funds are being devoted to expanding mobile crisis outreach through the state regardless of geography as part of the state's push towards statewide utilization of the CCBHC model.

b. Describe your state's targeted services to the homeless population.

“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.

c. Describe your state's targeted services to the older adult population.

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. BH Link has expanded to include a relationship with the Department of Elderly Affairs to include their staff to coordinate services for older adults. We also offer trainings for older adults through RI Office of Healthy Aging.

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, operations and the data and monitoring unit to the block grants. All these specialty staff are involved in the implementation of the plan. The Block grant planner and epidemiologist are 2 FTEs from operations fully attributed to the Block Grant to ensure the success of the assessment and plan and accurate, timely reporting. The now centralized Data unit assists the in the identification and analysis of data from our State's MMIS and RIBOLD databases. The Fiscal unit is also centralized and is responsible for all budget reports and invoices. Contracts is in the BH Division and includes one administrator and 4 contract monitors. Technical assistance and training is covered by one of three T/TA providers: one for MH/SA treatment, one for MH/SA recovery, and one for SA prevention/MH promotion.

Footnotes:

Environmental Factors and Plan

10. 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) Services for special populations:

Targeted services for veterans?	(•) Yes ( ) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

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. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) 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 Has your state identified a need for 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, and custody issues? ( ) 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 Quality Assurance Unit, which is part of Central Management branch of the Department takes complaints, grievances and does
investigations and creates plans of actions with the Licensing unit whenever policies regarding Block Grant are not followed by service providers. 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	(•) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(•) Yes ( ) No
c)	Outreach activities	(•) Yes ( ) No
d)	Syringe services programs, if applicable	(•) Yes ( ) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	( ) Yes (•) No
b)	Automatic reminder system associated with 14-120 day performance requirement	( ) Yes (•) No
c)	Use of peer recovery supports to maintain contact and support	(•) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?	(•) Yes ( ) No

3. States are required to monitor program compliance related to activites 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 Quality Assurance Unit, which is part of the Central Management division of the Department takes complaints, grievances and does
investigations and creates plans of actions with the Licensing unit whenever policies regarding Block Grant are not followed by service providers. 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? (•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	(•) Yes ( ) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	( ) Yes (•) No
c)	Established co-located SUD professionals within FQHCs	(•) Yes ( ) 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. BHDDH planning and data units can review the Medicaid claims data for SUD and TB and when appropriate works closely with the DOH to address any discrepancies. We've also recently begun partnering with RIDOH to flag potential increases in TB rates before they become problematic.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? (•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Establishment of EIS-HIV service hubs in rural areas	(•) Yes ( ) No
b)	Establishment or expansion of tele-health and social media support services	( ) Yes (•) No
c)	Business agreement/MOU with established community agencies/organizations serving persons	(•) Yes ( ) No

with HIV/AIDS

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.CÂ§ 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, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service 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. Has your state identified a need for 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 memebers, 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 services 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. Has your state identified a need for 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, such as 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. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (●) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — ( ) Yes (●) No
- **c)** 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. Has your state identified a need for 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 — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records — ( ) Yes (●) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — (●) Yes ( ) 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? — (●) Yes ( ) 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. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — ( ) Yes (●) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — (●) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — (●) Yes ( ) No

If Yes, please identify the accreditation organization(s)

i) [x] Commission on the Accreditation of Rehabilitation Facilities

ii) [ ] The Joint Commission

iii) [ ] Other (please specify)

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? ○ Yes ◉ No

2. Has your state identified a need for 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 ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ◉ 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 ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No

c) Performance-based accountability: ○ Yes ◉ No

d) Data collection and reporting requirements ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ◉ Yes ○ No

b) Addition of training sessions designed to increase employee understanding of recovery support services ◉ Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ 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 ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ◉ Yes ○ No

b) Mental Health TTC? ◉ Yes ○ No

c) Addiction TTC? ◉ Yes ○ No

d) State Targeted Response TTC? ○ Yes ◉ 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 ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ◉ Yes ○ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ◉ Yes ○ No

b) Professional Development ◉ Yes ○ No

c) Coordination of Various Activities and Services (●) Yes ( ) No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://rules.sos.ri.gov/organizations/title/212

BHDDH Regulations, Title 212, are in effect and are being explored for revisions at this time..

Footnotes:

Environmental Factors and Plan

11. 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 2020-FFY 2021? ○ Yes ◉ No

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

None needed at this time. We're in the middle of working on certification standards for behavior health. Once approved, we'll be able to modify our performance measures that are consistent with the NBHQF and we'll update on the report in December with progress.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] 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 M/SUD 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 M/SUD services. 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 M/SUD 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 M/SUD 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 Trauma[58] paper.

57 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.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD 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 M/SUD providers? ○ Yes ○ No

3. Does the state have a plan to build the capacity of M/SUD 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.

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

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Footnotes:

Environmental Factors and Plan

13. 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.[59]

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.[60]
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 the Health Insurance 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.

[59] 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 Ren?e L. Binder. **OJJDP Model Programs Guide**

[60] **http://csgjusticecenter.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 M/SUD 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, M/SUD 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 M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD 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 M/SUD 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?

In December of 2020, the state participated in virtual Sequential Mapping led by Justice System Training & Research Institute at Roger Williams University with technical assistance from Policy Research Associates with Justice Reinvestment funding.

One of our community healthcare organizations, Thundermist Health Center, is pursuing certification from CIT International for both a regional and statewide Crisis Intervention Team training program. Thundermist launched their first CIT program in Washington County in 2019 utilizing SAMHSA funds through the Washington County Health Equity Zone (HEZ). Their work expanded with support from the Rhode Island Police Chiefs Association utilizing funds through the Justice Reinvestment Fund, as well as grant funding through a federal Community Policing Development (CPD) Microgrant. In 2021, BHDDH became a grantee of the SAMHSA Early Diversion grant and entered into an MOU with Thundermist to execute a CIT academy in the Providence area and provide technical assistance as police departments statewide developed their own CIT programs. To date, Thundermist has certified more than 150 sworn police officers statewide in CIT training. In addition, they have engaged nearly 75 dispatchers, telecommunicators, peers and community advocates in specialized CIT trainings.

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

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14. Medication Assisted Treatment - Requested (SABG only)

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], 49 [4], and 63[5].

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.

TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]

TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]

TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]

TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

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)** ☐ Buprenophine, 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?

**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.*

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15. Crisis Services - Required for MHBG

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 M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] 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 M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"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 M/SUD 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.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. 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 check those that are used in your state:

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)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

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

• BHDDH is a part of ongoing technical assistance from the National Council for Mental Wellbeing's CCBHC Success Center to help build CCBHC infrastructure and sustain efforts achieved through CCHBH grants to local providers.
• BHDDH representatives are a part of ongoing workgroups with EOHHS and DCYF and other state agencies that serve children and families on the children's System of Care.
• BHDDH is a grantee of Vibrant Emotional Health 988 planning grant. The grant is providing technical assistance in the development of a 988 state implementation plan which will be completed in January of 2022.
• BHDDH representatives are working with our partners at Medicaid on their Request for Proposals for Managed Care services
• BHDDH will support Medicaid should they apply for the CCBHC planning grant from CMS
• EOHHS has secured the services of Faulkner Consulting to develop an implementation plan for CCBHCs

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

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD 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 M/SUD 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 to the greatest extent possible, 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. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. 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? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Block grant funding of recovery support services. (●) Yes ( ) 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 ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ( ) Yes (●) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

BHDDH funds 6 Recovery Community Centers that provide a variety of one-on-one and group peer based recovery support services (PBRSS) throughout RI, to people in recovery from mental illness, substance use disorder, and co-occurring disorders. RI is in the process of transitioning to a "hub and spoke" model for our RCCs, meaning that each RCC is the hub of all recovery services in its area. All services are provided by Certified Peer Recovery Specialists (CPRS), or people who are currently training to take their Peer Recovery Specialist Certification Exam. A snapshot of services provided includes: Individual coaching and support around setting and achieving goals, help navigating treatment systems, help advocating for yourself with your doctor or other professionals on your care team, support in accessing resources to meet basic needs (food, clothing, shelter), help getting and/or keeping a job, help starting and finishing training and education, guidance in exploring different pathways to and of recovery, referrals to mutual aid groups and other recovery support groups, support in accessing wellness tools, support in learning and practicing new skills. CPRS also facilitate Wellness Recovery Action Planning (WRAP) groups, Whole Health Action Management (WHAM) groups, and Life Skills groups. Lastly, RCCs host sober social/recreational events that are open to all.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

BHDDH funds 6 Recovery Community Centers that provide a variety of one-on-one and group peer based recovery support services (PBRSS) throughout RI, to people in recovery from mental illness, substance use disorder, and co-occurring disorders. RI is in the process of transitioning to a "hub and spoke" model for our RCCs, meaning that each RCC is the hub of all recovery services in its area. All services are provided by Certified Peer Recovery Specialists (CPRS), or people who are currently training to take their Peer Recovery Specialist Certification Exam. A snapshot of services provided includes: Individual coaching and support around setting and achieving goals, help navigating treatment systems, help advocating for yourself with your doctor or other professionals on your care team, support in accessing resources to meet basic needs (food, clothing, shelter), help getting and/or keeping a job, help starting and finishing training and education, guidance in exploring different pathways to and of recovery, referrals to mutual aid groups and other recovery support groups, support in accessing wellness tools, support in learning and practicing new skills. CPRS also facilitate Wellness Recovery Action Planning (WRAP) groups, Whole Health Action Management (WHAM) groups, and Life Skills groups. Lastly, RCCs host sober social/recreational events that are open to all.

5. Does the state have any activities that it would like to highlight?

We would like to highlight an activity aimed at increasing the competencies and leadership skills of CPRS, called the Leadership Fellows Academy (LFA). BHDDH is currently engaged in the planning process for this LFA. The LFA started in North Carolina, in response to a need for more Recovery Community Organizations and aimed to teach leaders with lived experience the technical and adaptive leadership skills they need to run sustainable organizations and increase their efficacy. We are bringing the LFA here to Rhode Island in Fall 2021 and will prioritize inclusion of CPRS that work at agencies we fund, such as RCCs. The LFA is an 8-month training process that is split into 2 phases. Phase 1 focuses on technical leadership skills such as non-profit governance, building for sustainability, grant writing, workforce development, business models, advocacy & public education, and branding. Phase 2 focuses on adaptive leadership skills such as appreciative inquiry, conflict management, moving past buy in to create engagement, belonging and ownership, the essentials of negotiating, the essentials of facilitative leadership, and seeking solutions that last for sharing power, collaboration, and partnership.
We have multiple goals we are trying to meet through this effort: The first is to produce a cohort of participants that view themselves as a collective community of leaders tackling complex social challenges and supporting each other, rather than a group of individual agencies competing against each other. Our second goal is to empower RI's RCC's and other Recovery Community Organizations to not only survive but thrive while they meet the needs of those they serve, by increasing their leadership skills and capacities.

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

None at this time.

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17. 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 M/SUD 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 M/SUD 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.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	○ Yes ○ No
Home and community based services.	○ Yes ○ No
Peer support services.	○ Yes ○ No
Employment services.	○ Yes ○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ○ Yes ○ No

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

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18. Children and Adolescents M/SUD 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 community.[63]. 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 24.[64]. 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 death.[65].

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 21.[66]. 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 costs.[67].

According to data from the 2015 Report to Congress[68] 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 M/SUD 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).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, 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.

[65]Centers 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.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department 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 **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? ( ) Yes (●) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

6. 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. Those services are being coordinated with contracted services through DCYF or the family private health insurance. There continue to be many cases 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. The Department has implemented the Pivot to prevention program which ensure early access to services ranging from moms who deliver babies expose to substances to children exiting the DCYF system across the life span. The Department continue to expand the array of Evidence Base practice services in order to assist families as their need arise.

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

During the COVID-19 pandemic, the Kid's Link information hotline has had over 10,000 calls (SFY2021). With the recent COVID-19

supplements, we're expanding programming to include two evidence-based programs, Strong African American Families and Homebuilders.

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

N/A

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19. Suicide Prevention - Required for 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 M/SUD 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 using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD 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.

There are currently Mental Health Block Grant COVID-19 funds set aside to create a MOU with RIDOH specifically for the creation of a suicide prevention strategic plan. The current suicide prevention plan was a five year plan that began in 2017 and will end in 2022 so this is a timely deliverable.

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 2020-FFY 2021 plan was submitted? ◉ Yes ○ No

If so, please describe the population targeted.

Mental Health First Aid training was implemented with Student Assistance professionals, middle and high school educators, other school staff, and Boys & Girls Clubs throughout the last federal fiscal year in partnership with the American Foundation for Suicide Prevention and the Bristol Health Equity Zone and Kent County Prevention Coalition. The Suicide Prevention hotline was added to BH Link recently and continues to have one of the highest in-state answer rates in the country. We continue to partner with RIDOH on suicide prevention initiatives.

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

N/A

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20. Support of State Partners - Required for 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 M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ○ Yes ◉ No

2. Has your state identified the need to develop new partnerships that you did not have in place? ◉ Yes ○ No

If yes, with whom?

BHDDH is in the infant stages of partnering with the faith-based community on implementing the Imani Project, including churches we haven't worked with before. We're also growing our relationship with the Narragansett Tribes with talks as recent as August 2021.

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

N/A

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and 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 an Advisory/Planning Council (PC).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 PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

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 M/SUD 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.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The Block Grant planner and epidemiologist put together a draft plan with input from internal agency staff and DCYF. The citizen log-in for WebBGas is advertised on the BHDDH website and provided to all Governor's Council members for comments and proposed edits to the application. At the June meeting, our partners at the University of Rhode Island presents the needs assessment completed for the purposes of the Block grant. Then, usually, at the August's Governor's Council meeting, staff and council members have time set aside to discuss the application before bringing it to a vote. The minutes and/or email including the vote to approve the application is then included as an attachment. This year, the August Governor's Council meeting was cancelled due to not reaching a quorum. Therefore, the application was provided to all Governor's Council members at the end of August, with a vote planned for the September meeting. For revisions, the Block grant planner will ask to reopen the application by mid-September for any and all approved Governor's Council revisions as well as the minutes from the September meeting.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? (●) 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 describe 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 functions of the council shall be:
(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 abuse and mental illness, focusing in particular on integrating support systems for behavioral health care;
(4) To act as the advisory committee to the department of mental health, retardation and hospitals and the governor on any funds made available to the department by the federal government for substance abuse and/or 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 the general assembly during the month of January, setting forth:
(ii) Such information and recommendations as the council deems necessary to deal with the problems as documented;
(iii) A review of the council's activities during the preceding year, including but not limited to, reports relative to activity, performance and need;
(iv) Any plans developed by the council to deal with the behavioral health care problems identified by the council;
(v) Other recommendations as may be appropriate and in the public interest.

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

N/A

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70]There 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.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

STATE OF RHODE ISLAND

Governor's Council on Behavioral Health
14 Harrington Road
Cranston, RI 02920
Tel: (401) 462-1550
Email: Tia.Micek@bhddh.ri.gov

Meeting of The Governor's Council on Behavioral Health
Second Thursday of every month; 9:00 a.m. - 10:30 a.m.

Thursday, June 10, 2021

Richard Leclerc opened the meeting at 9:07 a.m. via Zoom.

The meeting included a presentation of block grant needs assessment and areas of the application prior to submission, including a review of metrics by Amanda Roy and Jesse Sullivan of URI

The meeting included an open discussion with council members and public attendees about COVID-19 block grant supplement funding uses

The meeting included department and committee updates

The meeting adjourned at 10:30 a.m.

A recording of the June Governor's Council on Behavioral Health can be found at:

Governor's Council on Behavioral Health (June2021) - YouTube

The next meeting of The Governor's Council on Behavioral Health will be held on **Thursday, July 8, 2021 at 9:00 via Zoom.**

https://us02web.zoom.us/j/3333965778?pwd=UGxsc2V2OHRJQll5aFhYcEJ3bHdSZz09

BLOCK GRANT NEEDS ASSESSMENT

Amanda Roy & Jesse Sullivan, University of Rhode Island
in partnership with BHDDH (Candace Rodgers & Dr. Samantha Borden)

Thursday, June 10, 2021
Governor's Council on Behavioral Health Meeting

Learning Objectives

1. Review Community Mental Health Services (CMHS) and Substance Use Prevention Treatment (SAPT) Block grant requirements, including the biennial combined Block grant needs assessment.

2. Discuss the results of the biennial Block grant needs assessment for federal fiscal years 2022 and 2023 (FY2022/2023).

3. Examine lessons learned and next steps regarding the needs assessment process while improving the quality of the next needs assessment cycle.

Background

Background

- In Rhode Island, we utilize a combined application for the Community Mental Health Services (CMHS) and Substance Abuse Prevention Treatment (SAPT) Block grants. The FY2022/2023 application is due 9/1/2021.
  - The purpose of the SAPT Block grant provides a continuum of prevention, early intervention, treatment, and recovery services for substance use disorders, and works to ensure treatment services for uninsured, underinsured, and undocumented Rhode Islanders.
  - The purpose of the CMHS Block grant provides an array of services for individuals with serious mental illness (SMI), serves youth and young adults experiencing first episode psychosis (FEP), and serves children with serious emotional disturbance (SED).

Background Continued

SAPT

- 20% of funds minimum spent on primary prevention
- Maintenance of effort on women's services
- Maintenance of effort on SA services

CMHS

- 10% minimum on children with serious emotional disturbance
- 10% minimum on youth and young adults with FEP
- NEW 5% crisis services set aside
- Maintenance of effort on MH services

Background

- As part of the application, the state is required to conduct a biennial needs assessment that answers the following question:

  What are the unmet service needs and critical gaps within the current system?

- To do this work, BHDDH partners with URI as part of a workforce development program.

- This cycle, our process got a late start because of the COVID-19 pandemic. URI began the assessment around the time EOHHS was launching their evidence update.

- We took a different approach to make up for lost time—reviewed several of the last needs assessments to see if the same themes came up and assessed what changes have been made, or still need to be made. We also included questions regarding the COVID-19 pandemic and how that affected the needs for the next application.

Methods

Methods – Materials

- Survey published on Qualtrics and was open from mid December 2020 to March 31, 2021.
  - Potential respondents were contacted through email listservs or by snowball sampling methods.
  - Number of questions varied in length depending on whether they were a provider, consumer, or family member.
  - Five e-mail addresses have been drawn to win a gift card for completing the survey. These individuals will be contacted **this week** by BHDDH.

- Focus groups questionnaire consisted of six open-ended questions.
- Conducted one in Late February and one in early March
  - First aim: Address the gaps identified from the 2018 BGNA and track any changes since then.
  - Second aim: Identify how COVID-19 impacted service delivery, treatment, and prevention efforts throughout the state.

Methods – Participants

- RI Behavioral Healthcare Community Survey
  - Providers (N=223)
  - Consumer (N=28)
  - Family Members (N=33)
- State Staff Focus Groups (K=2)
  - State-Level Administrators (N=12)

RESULTS

RI Behavioral Healthcare Community Survey

Provider Responses by Regions	Percent
Area 1: Burrillville, Cumberland, Lincoln, North Smithfield, Woonsocket	16.6
Area 2: Pawtucket, Central Falls	3.4
Area 3: Providence	26.3
Area 4: Foster/ Glocester, Scituate, Smithfield, Cranston, Johnston, North Providence	8.0
Area 5: Coventry, East and West Greenwich, Warwick and West Warwick	8.6
Area 6: Block Island, Charlestown, Exeter, Hopkinton, Narragansett, North and South Kingston, Richmond, and Westerly	6.3
Area 7: Barrington, Bristol, East Providence, Warren	6.3
Area 8: Jamestown, Little Compton, Middletown, Newport, Portsmouth, Tiverton	20.0
Statewide	4.6

Importance of Providing Mental Health Services 1 (Not Important) - 5 (Very Important)	Average Response
In jails	4.95
In DV shelters	4.93
In schools	4.92
In homeless shelters	4.91
In Federally Qualified Health Centers	4.89
In emergency departments	4.87
In primary care	4.79
In homes	4.75
In a language other than English	4.59
In senior day centers	4.66
In assisted living facilities	4.59

Importance of Providing SUD Services 1 (Not Important) - 5 (Very Important)	Average Response
In jails	4.85
In DV shelters	4.84
In homeless shelters	4.83
In emergency departments	4.82
In Federally Qualified Health Centers	4.78
In primary care	4.68
In schools	4.60
In a language other than English	4.59
In homes	4.45
In assisted living facilities	4.20
In senior day centers	4.17

Barriers to Mental Health Services 1 (Never Experience) - 5 (Experience Very Often)	Average Response
Transportation	3.95
Stigma	3.93
Not know how to access services	3.82
Cost of services	3.40
Services offered at inconvenient times	3.36
Racial and ethnic differences	3.22
Not provided in a trauma responsive way	2.98

Barriers to SUD Services 1 (Never Experience) - 5 (Experience Very Often)	Average Response
Stigma	4.04
Transportation	3.93
Not know how to access services	3.70
Cost of services	3.11
Services offered at inconvenient times	3.08
Racial and ethnic differences	2.90
Not provided in a trauma responsive way	2.77

Helpful to Accessing Mental Health Services 1 (Not Helpful) - 5 (Very Helpful)	Average Response
Telemedicine services	4.76
Transportation services	4.74
Mobile treatment unit	4.63
Walk-in appointments	4.60
Services in languages other than English	4.59
Bus pass voucher	4.52
Appointment reminders	4.50
Flexible payment plan	4.41
Services online	4.39
Service for deaf/hard of hearing	4.22
Service for visually impaired	4.20

Helpful to Accessing SUD Services 1 (Not Helpful) - 5 (Very Helpful)	Average Response
Transportation services	4.79
Telemedicine services	4.70
Mobile treatment unit	4.64
Walk-in appointments	4.58
Services in languages other than English	4.56
Bus pass voucher	4.55
Flexible payment plan	4.38
Services online	4.30
Appointment reminders	4.26
Service for deaf/hard of hearing	4.19
Service for visually impaired	4.14

Impact on Mental Health Services Provision 1 (Does not impact) - 5 (Highly impacts)	Average Response
A lack of state funding for programs	4.64
Lack of appropriate or timely reimbursement	3.93

State Staff Focus Groups

Thematic Analysis

- Thematic analysis was conducted on the two focus groups to assess key strengths and weaknesses of the current state of behavioral healthcare in Rhode Island.
- 55% Thematic Agreement was reached between the two focus groups transcripts and the three coders.
- Most Codes were derived from the 2018 BGNA, with the exception of the COVID-19, Telehealth, and Staffing codes.

COVID-19

Throughout the focus groups, participants mentioned the COVID-19 pandemic a total of 60 times.

You'll see these themes represented throughout the following slides.

"We have a couple of our detoxes that are at risk right now because they're gonna have lower income and higher expenses because of purchasing PPEs, cleaning requirements. You used to have four people to a room, now you'd only have two people, so your income considerably drops."

Funding

Participants mentioned funding 35 times

- In the context of COVID-19, funding was discussed both positively and negatively
  - Costs for maintaining residential treatment centers increased, but their income drastically decreased due to social distancing
  - However, COVID grants aided in offsetting these costs and helped finance the transition into telemedicine
- Funding for staff is subpar "Make just as much money working in Target…"
- Funding has aided in an increase of culturally competent services
- Short term versus long term funding
- Funding for all substances equally is desired, not just opiates
- Advancements have led to things like reimbursement for peer recovery specialists.

"A lot of the funding that we have, the funding sources are time limited. And so it makes it hard, you know, in some cases agencies don't want to hire somebody if they know that the funding could go away in a year or two. So that, that's presents a challenge."

Outreach

- Mentioned 32 times throughout the focus groups
- Prevalent in the context of the COVID-19 Pandemic
  - The transition into telehealth services, Naloxone distribution and MAT efforts thriving during COVID lockdown
  - The impact of overdose and overdose-related deaths on outreach efforts
    - Noted increase of outreach efforts in the past two years (i.e. HOPE initiative, ribhopenbeds.org), specific grants (i.e. PATH), finding creative ways to reach potential clients (i.e. podcasts)
    - Uneven distribution of outreach efforts (i.e. oversaturation of efforts in Providence)
    - Need for a better working definition of outreach
    - Better data around overdoses to inform rapid response efforts

Housing

The Housing theme was mentioned a total of 25 times

- The COVID-19 Pandemic (reduced room capacity, facilities at risk of closing, COVID relief dollars helping to identify housing units…)
- Increase in the number of shelters (e.g. COVID-19 hotel program)
- Hotel programs fostering engagement in services
- Lack of affordable/stable housing preventing the completion of a treatment plan
- Increase in homelessness
- Working with funders like Medicaid to fund home stabilization
- Increased collaboration among providers ("100 people have been moved into stable housing")

"the lack of housing units is, is a huge problem. I mean, we know that when people are stably housed, they do better in their recovery. So this is a critical, you know, need for us"

Cultural Competency

Participants mentioned cultural competency 18 times

- Elderly clients not being able to fully access telehealth services due to limits with technology
- Successful partnerships with agencies like DORCAS international that aid in reducing cultural barriers
- Lack of equity
- Culturally competent trainings, and the participants from diverse backgrounds
- How to collect data on race, ethnicity culture, etc.,
- PBS "opioids in the community" presentations in Spanish

"There's still a great deal of people paying attention to equality, which is good. But there's there's a problem with equity when, as [Participant 2] said, people are having to continue to place that pie thinner and thinner, as far as their resources go, with less and less money and expecting to have positive outcomes and the ability to produce and provide quality services."

General Facilitators to Services and/or Treatment

Participants mentioned a total of 17 general facilitators to services and or treatment

- Adaptability in the face of the COVID-19 pandemic (i.e. implementing lockboxes for naloxone and telehealth for services)
- Warm handoffs between providers
- Having services like the hotel program set up that make service accessibility mutually beneficial
- Increased communication and MOU's between funders and providers
- Sharing/dissemination of resources between staff and agencies

"it started with the methadone clinics; there was a change in take home, so people were allowed to have their medications — take them home and lock boxes versus going to the clinics every day to reduce the concerns around COVID-19."

Improvement Ideas

Participants mentioned Improvement ideas 17 times

- Starting more ACT or IHH teams
- Making better use of the technology we already have
- Better supporting individuals with the digital transition
- Incentivizing service delivery as a way to increase access to services
- Increase crisis intervention training
- Actually pay workers "appropriate rates" for services
- Fund mental health and substance use services equally
- Make Olmstead a priority and find outside advocates to take up the mantle
- Strive for a representative workforce, educate staff and providers on racial/ethnic inequality

"I mean, we've discussed workforce development in the past, and the need for that, because we don't have an adequate workforce that represents the populations that we're serving."

Staffing

The Staffing theme was mentioned 14 times throughout the focus groups

- Not being able to retain staff/difficulties hiring staff, regardless of funding (though funding has helped increase staffing at some agencies)
- Unclear job/role responsibilities
- Staff not fulfilling their roles/duties (e.g. not actively engaging clients and providers)
- Different roles staff can fill (i.e. CPRS)
- The workforce being strong despite the present barriers

"We've been getting a lot of different funding in to try to help us cope with COVID prices, and deal with a lot of these things, and just finding staff to do these jobs is really difficult. I mean, we're very grateful for the funding, but we've been having a difficult time getting things moving..."

Telehealth

Telehealth emerged out of the COVID-19 theme and was mentioned a total of 13 times

- Praises include some populations preferring telemedicine and the increased access to services, especially for those who may have been previously harder to reach because of transportation barriers
- Drawbacks consisted of a lack of anonymity, potential issues with lack of technology/wifi, not being able to use the services because of a lack of tech knowledge or savvy, and different levels of comfort with the use of telehealth for both clients and providers

"When you talk about telehealth services again, it's the accessibility, the equipment, that they may not have the equipment. I mean, people don't think about it, but just in terms of being able to charge phones. If you don't have any place to get in from the outside, where are you going to charge the phones or whatever equipment that you know, you are using."

Adolescent Care

The Adolescent Care theme was mentioned a total of 12 times in the context of:

- The COVID-19 Pandemic (especially with regards to youths and telehealth services)
- Outreach/prevention efforts
- Increased substance use/mental health concerns
- Specific services covered by the SAPT/CMHS for youths (i.e. triage assessment at Bradley KidsLink).

"And while COVID is terrible, it also has been positive in some aspects, because there's some youth and young adults that don't like to sit on the proverbial Freudian couch. They'd rather take a walk, do it via telehealth, because then they don't have to do eye to eye therapy. And that's very important for youth."

General Barriers to Services and Treatment

Participants mentioned general barriers to services and treatment 9 times in the context of:

- The COVID-19 Pandemic
- Systemic barriers (e.g. homelessness)
- Services being "at capacity" or not being accessible
- Staff not being able to advocate for clients

"Because of the barriers of getting people into mental health treatment in particular, it's easier for us to provide those services on the street than it is to try to get them into, into agencies … the services, the agencies, for whatever reason, will not make some of the appointments or they don't have staff available to have the appointments."

Transportation

The Transportation theme was mentioned a total of 7 times

- The COVID-19 Pandemic
  - Greater hesitation around using public transportation like RIPTA
- Other barriers to services or treatment (i.e. "clunkiness", and the lack of busses preventing individuals from being able to make it to their appointments on time).

"Transportation is a huge issue, so people who are homeless, for example, can't get to the agencies unless we have somebody to transport them. And they missed their appointments and then they're just charged. Then they you know, um, decompensate and we're back to having them either in the prison or inpatient services. So it is a, it's a major issue."

Trauma Informed Care

Participants referenced Trauma Informed Care 5 times in the context of

- The COVID-19 Pandemic
- Training curriculums (such as Crisis Intervention Team Training)
- Treatment screening

"I've-there've been a recent interest in something called Cahoots and just crisis response services in general. As I pointed out, the law enforcement is becoming more interested in getting the crisis intervention training, also known as CIT training. But you also have a lot of people out there — legislators and other movers and shakers — interested in crisis services. And there's a model called Cahoots that's been getting some play. It was initiated in Oregon, but its peer-run, and as the peer-run services are becoming more popular in getting more into sort of the limelight, this model has been sort of introduced and come to the forefront. And I participated in a phone call, and I've worked in this field now for 20 years in Rhode Island, and I've never seen more peers more excited about anything before since I've been here"

DISCUSSION

Limitations

- The surveys completed by consumers and family members of consumers had low participation and could not be analyzed in a statistically relevant way.
- The provider survey responses corresponded with the type of providers who participated. For example, we noticed a lot of individuals working with DOC responded to the survey and one of the most prevalent responses was that services being provided in jails were a high need.
- We were unable to capture client feedback for focus groups, so our view focused on provider feedback and input.

Lessons Learned

1. Consumer and family response rates to the survey were very low
   - Utilize quarterly town hall meetings for feedback
   - Work with advocacy organizations such as NAMI, MHA, and RICARES

1. Provider survey responses gave little range of priorities within a Likert scale
   - Change Likert scale to rank order for priorities so there's more variation

1. The regular needs assessment process is being manualized
   - Request that the State Epidemiological Outcomes Workgroup provide feedback to improve the process
   - Will be sent to Governor's Council on Behavioral Health for approval and implemented every other year to collect data that is comparable over time

Conclusions

- The combined Community Mental Health Services (CMHS) and Substance Abuse Prevention Treatment (SAPT) Block grants require a biennial needs assessment
- The provider survey suggests the following infrastructure changes could be beneficial:
  - Increase services in more locations such as jails, shelters, schools, homes
  - Address barriers related to transportation, stigma, and the cost, time, and knowledge of how to access services
  - Consider improving access to services by offering telemedicine, transportation assistance, mobile treatment, walk-in appointments, appointment reminders, flexible payment plans, and services for clients who don't speak English, who are deaf or hard of hearing, and/or who are visually impaired
- The focus groups emphasized that trends in barriers observed from the 2018 BGNA are still prevalent (e.g. housing and transportation are still large issues).

Conclusions

- Strides are being made in adolescent care, especially with the COVID-19 related promotion of Bradley Hospital's KidsLink. This is helpful considering one of the main conclusions from the 2018 BGNA was the identification of major gaps within the adolescent care realm (Tate et al., 2018).
- Lastly, COVID-19 pandemic had an impact on every facet of this needs assessment, but under the circumstances, adapting to online platforms and telemedicine was adopted quickly and efficiently by providers across the continuum of care.

THANK YOU

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Additional Positive Themes

Some positive themes surrounding the state of behavioral healthcare in RI were:

- Continued data collection (e.g. RI Student Survey) and dissemination of findings despite COVID-19
- Innovative approaches to COVID-19-related barriers
- Increase in culturally competent and trauma-informed/recovery-oriented services
- Increase in training/education efforts and discussion (i.e. medication assisted treatment, crisis intervention services…)
- Increased coordinated care

Additional Negative Themes

Some negative themes surrounding the state of behavioral healthcare in RI were:

- Systemic issues
  - Homelessness, Basic client needs not being met
- Increase in adolescent substance use
- Issues with managed care

"...So if what you're being judged on is outcomes, there's a perverse incentive to discharge people who are extremely difficult and complicated clients. So you put in place policies that make it very difficult for these people to access services. When they don't access the services, for example, missing three appointments in a row, you discharge them, and you're no longer responsible for the outcome for those individuals. So your outcomes look much better than they would if you were actually providing the services that you're supposed to be providing."

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Nicole Alexander-Scott	State Employees	RI Department of Health	3 Capitol Hill Providence RI, 02908	
Richard Antonelli	Others (Advocates who are not State employees or providers)	public member	41 West Rd. Cranston RI, 02920	
Kevin Aucoin	State Employees	RI Dept. of Children, Youth and Families	101 Friendship St. Providence RI, 02903	
Linda Bryan	Parents of children with SED/SUD	public member	41 West Rd. Cranston RI, 02920	
Kathleen Calandra	Providers	Healthcentric Advisors	235 Promenade St 500 Providence RI, 02908	kcalandra@healthcentricadvisors.org
Richard Charest	State Employees	Dept of Behavioral Healthcare, Developmental Disabilities & Hospitals	41 West Rd. Cranston RI, 02920	
Megan Clingham	State Employees	Office of the Mental Health Advocate	57 Howard Ave Cranston RI, 02920	
Patricia A. Coyne-Fague	State Employees	RI Dept. of Corrections	P.O. Bpx 8274 Cranston RI, 02920	
Sandra DelSesto	Others (Advocates who are not State employees or providers)	public member	41 West Rd. Cranston RI, 02920	
Sarah Dinklage	Providers	RI Student Assistance Program	300 Centreville Rd. Warwick RI, 02886	
Cindy Elder	Family Members of Individuals in Recovery (to include family members of adults with SMI)	public member	41 West Rd. Cranston RI, 02920	
Mark Fields	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	public member	41 West Rd. Cranston RI, 02920	
Karen Friend	Others (Advocates who are not State employees or providers)	Pacific Institute for Research and Evaluation	255 Hope Street Providence RI, 02906	kfriend@PIRE.org
Ines Garcia	Parents of children with SED/SUD	public member	41 West Rd. Cranston RI, 02920	
Jennifer Griffith	State Employees	RI Child Advocate	57 Howard Ave Cranston RI, 02920	

Michael J. Hogan	State Employees	RI Public Safety Grant Admin Office	One Capitol Hill Providence RI, 02908	
Linda Hurley	Providers	CODAC	1052 Park Ave Cranston RI, 02920	
Womazetta Jones	State Employees	RI Executive Office of Health and Human Services	57 Howard Ave Cranston RL, 02920	
Richard LeClerc	Others (Advocates who are not State employees or providers)	public member	41 West Road Cranston RI, 02920	
Wendy Looker	Providers	CTR	82 Pond St. Pawtucket RI, 02860	wendy@methadoneri.com
Jim McNulty	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	public member	41 West Rd. Cranston RI, 02920	
Anne Mulready	Others (Advocates who are not State employees or providers)	RI Disability Law Center, Inc.	275 Westminster St. Providence RI, 02903	
Peter Neronha	State Employees	RI Office of the Attorney General	4 Howard Ave. Cranston RI, 02920	
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 St. Pawtucket RI, 02860 PH: 401-739-1262	
Obed Papp	Providers	City of Providence	25 Dorrance Street Providence RI, 02903	opapp@providenceri.gov
Esther Picone	Parents of children with SED/SUD	public member	41 West Rd. Cranston RI, 02920	
Ronald Racine	State Employees	RI Dept. of Human Services-Voc. Rehab.	57 Howard Ave. Cranston RI, 02920	
Janet Spinelli	Others (Advocates who are not State employees or providers)	public member	41 West Rd. Cranston RI, 02920	
Susan Storti	Providers	SUMHLC	200 Metro Centre Blvd. Warwick RI, 02886 PH: 401-521-5759	
Brian Sullivan	Providers	Operation Stand Down	164 Broadway Newport RI, 02840 PH: 401-383-4750	
Michelle Szylin	State Employees	RI Office of Healthy Aging	74 West Rd. Cranston RI, 02920	
Michael Tondra	State Employees	Rhode Island Office of Housing and Community Development	One Capitol Hill Providence RI, 02908 PH: 401-222-7901	
Alice Woods	State Employees	RI Dept. of Education	255 Westminster St. Providence RI, 02903	

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Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**33**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	3	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	1	
Parents of children with SED/SUD*	3	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	6	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**13**	**39.39%**
State Employees	13	
Providers	7	
Vacancies	0	
Total State Employees & Providers	**20**	**60.61%**
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**	
Youth/adolescent representative (or member from an organization serving young people)	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?

So far for this application cycle, the Planning Council provided feedback on the needs assessment and on supplemental funding ideas. Due to a cancelled August meeting and the late release of the Block grant application this year, we did not get to discuss the application itself prior to the 9/1 submission date. It'll be discussed at the September meeting with either an in-person or virtual vote, pending revisions from the membership. Also, this is the second year in a row in which our membership balance was off, with less than 50% of members being in Recovery, Family Members or Others. To help mitigate this in the future, we've written in deliverables into all our advocacy and education contracts on the MH and SA Block grant that they are to help us try and recruit members to the Governor's Council. It's also been flagged to our agency's chief of staff to help resolve within the next legislative

session (members need to be confirmed by state legislators).

Footnotes:

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22. 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

If yes, provide URL:

https://bhddh.ri.gov/substance-useaddiction/block-grant-information#:~:text=BHDDH%20submits%20a%20biennial%2C%20combined%20Substance%20Abuse%20%28SA%29,prevention%2C%20treatment%2C%20and%20recovery%20programs%20throughout%20Rhode%20Island.

c) Other (e.g. public service announcements, print media) ( ) Yes (●) No

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23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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