Rhode Island

UNIFORM APPLICATION
FY 2024 SUPTRS Block Grant Report

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/15/2023 - Expires 06/30/2025
(generated on 12/06/2023 7.47.31 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

I: State Information

State Information

I. State Agency for the Block Grant

Agency Name	Rhode Island Department of Behavioral Healthcare, Developmental Disabilties and Hospitals (BHDDH)
Organizational Unit	Division of Behavioral Health
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III. Expenditure Period

State Expenditure Period

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

Block Grant Expenditure Period

From	10/1/2020
To	9/30/2022

IV. Date Submitted

Submission Date	12/1/2023 1:16:15 PM
Revision Date	12/1/2023 1:16:50 PM

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Footnotes:

II: Annual Update

Table 1 Priority Area and Annual Performance Indicators - Progress Report

Priority #: 1

Priority Area: Youth

Priority Type: 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).

Objective:

To reduce the prevalence of youth use of illegal substances including alcohol, marijuana, prescription drugs (not prescribed to them) tobacco, and tobacco-related products.

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.

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

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.

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

Data Source:

Rhode Island Student and Youth Risk Behavioral Surveys (RISS; RI YRBS)

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

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.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

Reason why target was not achieved, and changes proposed to meet target:
We did not meet the stabilization of the 30-day use percentages for alcohol or marijuana during this time period. We had rates of 12.4% for alcohol and 12.4% for marijuana. We believe that the covid-19 pandemic influenced 30-day use of alcohol increased due to several reasons: 1) Adult alcohol use increased during this time period 2) Alcohol became more available during the covid-19 pandemic with drive thru and delivery services becoming wide-spread in Rhode Island. We believe that the 30-day marijuana use increased due to these reasons 1) Marijuana legalization was on the horizon for Rhode Island. 2) The neighboring state of Connecticut legalized during this time period.

How first year target was achieved *(optional)*:
We met the goal of stabilization and decrease of 30-day use of tobacco at 3.4% and electronic delivery system (ENDS) devices at 30.1%.

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

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

The 1% decrease from our baseline which was 8.61% was not meant for 30-day use of marijuana. Our 30-day marijuana use rate from the 2022 RI Student Survey (RISS) was 9%. However, based on our RISS data we did see a decrease from the 2020/2021 at 12.4% to the 2022 10%.
Also, we did not meet the 1% decrease for prescription drugs and cigarettes but did see an overall decrease with 30-day use of cigarettes decreasing from 3.79% to 3% and 30-day use of prescription medication decreasing from 2.38% to 2%,

How second year target was achieved *(optional)*:

We met our second-year target for 30-day use of alcohol from 10.39% to 9% and ever used electronic nicotine devices from 40.3% to 22%.

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)

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

Data Source:

Rhode Island Student and Youth Risk Behavior Surveys

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

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.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

Reason why target was not achieved, and changes proposed to meet target:
We did not meet the target of increasing perception of risk of harm for alcohol or marijuana. Alcohol decreased to 43.6% and Marijuana to 45.8%. We believe that the covid-19 pandemic influenced the perceived risk of harm of alcohol due to several reasons: 1) Adult alcohol use increased during this time period 2) Alcohol became more available during the covid-19 pandemic with drive thru and delivery services becoming wide-spread in Rhode Island. We believe that the perception of risk of marijuana decreased to these reasons 1) Marijuana legalization was on the horizon for Rhode Island. 2) The neighboring state of Connecticut legalized during this time period.

How first year target was achieved *(optional)*:

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

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

We did not meet the second-year target of increasing perception of risk of harm by 2% for marijuana, alcohol and prescription drugs. The rates are alcohol decreased to 62%, marijuana 38%, and prescription drugs 74%.

How second year target was achieved *(optional)*:

Priority #: 2

Priority Area: Persons Who Inject Drugs

Priority Type: SAT

Population(s):

Goal of the priority area:

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

Objective:

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of unique contacts who met with a recovery coach through Anchor's ED program and/or recovery community center ED outreach

Baseline Measurement: 1,200

First-year target/outcome measurement: 1,200

Second-year target/outcome measurement: 1,200

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

Data Source:

Anchor ED and/or recovery community center ED reporting to the BHDDH Contract Monitoring Unit

New Data Source*(if needed)*:

Description of Data:

Our goal is to continue to reach about 100 new individuals each month through this program. 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.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

Reason why target was not achieved, and changes proposed to meet target:
The programs have been administered for 9 months, meaning 3 months of data have not been collected. Additionally, since the requirement is for unique contacts, the ceiling may have been met with reaching the majority of the population, at least once.

How first year target was achieved *(optional)*:

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

How second year target was achieved *(optional)*:

1,364 contacts who met with a recovery coach through Anchor's ED program and/or recovery community center ED outreach

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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

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

Data Source:

Anchor MORE reporting to the BHDDH Contract Monitoring Unit and/or recovery community center reporting to the BHDDH Contract Monitoring Unit

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved *(optional)*:
Additional agencies provided outreach support and emergency department support. Their numbers were also included in the count.

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

How second year target was achieved *(optional)*:

37,207 received outreach/contact with a recovery coach through Anchor MORE/recovery community center outreach programs

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.

Objective:

1. By 9/30/2022, 120 individuals experiencing chronic homelessness will be placed in supportive housing.
2. By 9/30/2022, SOAR approval rate for individuals experiencing chronic or long-term homelessness will remain above 80%.

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).

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

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

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

Data Source:

Homeless Management Information System (HMIS)

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

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.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved *(optional)*:

The organization, the Coalition to End Homelessness, reported the data. The target population received outreach services through multiple service providers. RI practices the Housing First model and is committed to obtaining housing for our population. 446 individuals were placed in supportive housing

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

How second year target was achieved *(optional)*:

There were 535 individuals housed over the span of last year. This number includes those individuals who experienced chronic homelessness and long-term homelessness.

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%

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

Data Source:

SAMHSA SOAR OAT data base

New Data Source*(if needed)*:

Description of Data:

Description of data: Provides state data on SOAR approval rates.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

N/A

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

Reason why target was not achieved, and changes proposed to meet target:
The population size is very small, and the results cannot be generalizable. 2 out of 35 clients were approved for SSI. Staffing shortages and other pandemic related problems continue to impede progress.

How first year target was achieved *(optional)*:

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

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

The approval rate for SOAR was 28%. There were 7 successful cases out of 25. This program is administered by another organization, outside of BHDDH.

How second year target was achieved *(optional)*:

Priority #: 4

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

Priority Type: MHS

Population(s): Other

Goal of the priority area:

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

Objective:

By September 2023, increase the number of youth and young adults receiving services through Healthy Transitions' Coordinated Specialty Care interventions.

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.

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth and young adults ages 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

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

Data Source:

Healthy Transitions contract monitor reporting from service providers to BHDDH

New Data Source*(if needed)*:

Description of Data:

All contracts, whether funded by discretionary funding or Block grant funding, include data reporting requirements including this metric.

New Description of Data:*(if needed)*

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.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved *(optional)*:

There were 164 reported via our electronic reporting system. These totals were from the 3 providers that directly contract with BHDDH. Two other providers did not report numbers since they don't have contracts. There has been considerable focus this year on training FEP providers to increase clinical skills and services. This may have contributed to the identification of individuals in need of services and targeted outreach activities.

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

How second year target was achieved *(optional)*:

123 youth and young adults receiving services from 4 HT provider sites that reported to BHDDH during this time period

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.

Objective:

Strategies to attain the goal:

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

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

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

Data Source:

MMIS

New Data Source*(if needed)*:

Description of Data:

Medicaid claims data for IHH/ACT members

New Description of Data:*(if needed)*

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.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved *(optional)*:
Considerable work has focused on community stabilization this past year.

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

How second year target was achieved *(optional)*:

Inpatient readmissions within 30 days in 2023 was 258. Rhode Island focused on the client flow between community services and inpatient units to improve communication and referral processes. This work is believed to have positively impacted this outcome.

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

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

Data Source:

MMIS

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

N/A

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved *(optional)*:
The number of admits to the ED are on a positive downward trajectory. The baseline above should indicate the target outcome should be less than the target outcomes.

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

How second year target was achieved *(optional)*:

The number of visits per 1000 member months was 92 for the 2023 report. Although the number increased from 2022, which was 82, this years results are below the baseline. Additionally, the numbers for Rhode Island are small due to population size. Slight fluctuations have a large impact on the percentage.

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

Objective:

By September 2023, increase the percentage of unique individuals assessed by BH Link age 60+

Strategies to attain the goal:

Targeted outreach for BH Link to older adults

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

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%

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

Data Source:

BHDDH Pulse Deck Reporting to EOHHS

New Data Source*(if needed)*:

Description of Data:

BHDDH regularly meets and discusses data with EOHHS. This is one of the metrics we provide on a regular basis.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None at this time

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

Reason why target was not achieved, and changes proposed to meet target:
The baseline was determined during a pandemic. The indicator will be changed in the next cycle to reflect a number served rather than a percentage of the whole to insure targeted outreach.

How first year target was achieved *(optional)*:

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

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

BH Link assessed 117 individuals over age 60 which accounts for 7% of the total population. This indicator is being removed due to lack of relevance.

How second year target was achieved *(optional)*:

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.

Objective:

By September 2023, increase the number of families receiving services through warm lines, visits, meetings, phone calls, workshops, activities, and conferences.

Strategies to attain the goal:

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

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

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

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

Data Source:

Kid's Link reporting metrics from Bradley Hospital

New Data Source*(if needed)*:

Description of Data:

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Possible duplication on individuals

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved *(optional)*:
Kids Link received well above the number of calls anticipated. This is believed to be caused by the exasperation of behavioral health issues caused by the pandemic.

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

How second year target was achieved *(optional)*:

Kid's Link received 8,092 calls.

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

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

Data Source:

MIS

New Data Source*(if needed)*:

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.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

N/A

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved *(optional)*:
The programs saw almost a duplicate number of clients served as last year, 986.

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

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

The target was 900 however, the outcome was 834 families with children were served.

How second year target was achieved *(optional)*:

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

III: Expenditure Reports

Table 2 - State Agency Expenditure Report

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

Expenditure Period Start Date: 7/1/2022 Expenditure Period End Date: 6/30/2023

Activity (See instructions for entering expenses in Row 1)	A. SUPTRS BG	B. MHBG	C. Medicaid (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19[1]	I. ARP[2]
1. Substance Use Prevention (Other than Primary Prevention), Treatment, and Recovery[3]	$2,896,154.01		$0.00	$8,351,005.16	$1,265,973.06	$0.00	$0.00	$2,023,047.89	$210,906.51
a. Pregnant Women and Women with Dependent Children	$42,081.08		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. Recovery Support Services	$1,136,590.62		$0.00	$3,178,028.14	$419,834.41	$0.00	$0.00	$215,258.17	$4,288.59
c. All Other	$1,717,482.31		$0.00	$5,172,977.02	$846,138.65	$0.00	$0.00	$1,807,789.72	$206,617.92
2. Substance Use Disorder Primary Prevention	$3,417,574.04		$0.00	$4,535,099.70	$901,700.86	$40,000.00	$0.00	$2,135,560.70	$261,288.32
3. Tuberculosis Services	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV)[4]	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
5. State Hospital									
6. Other 24 Hour Care									
7. Ambulatory/Community Non-24 Hour Care									
8. Mental Health Primary Prevention									
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)									
10. Administration (Excluding Program and Provider Level)	$332,301.48		$0.00	$2,576,572.02	$2,037,033.47	$0.00	$0.00	$218,874.14	$4,463.09
11. Total	**$6,646,029.53**	**$0.00**	**$0.00**	**$15,462,676.88**	**$4,204,707.39**	**$40,000.00**	**$0.00**	**$4,377,482.73**	**$476,657.92**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions (NoA). Per the instructions, the standard SUPTRS BG expenditures are for the state planned expenditure period of July 1, 2023 – June 30, 2025 for most states.

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

[3]Prevention other than primary prevention

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

Please indicate the expenditures are actual or estimated.

(●) Actual ( ) Estimated

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Footnotes:

Increase from previous year (Column E) due to new allocation of state funding from opioid settlement which necessitated an increase in staffing to administer funds.

The expenditures reported in this table are taken from the state's accounting system and are based on posted expenditures.

III: Expenditure Reports

Table 3a – Syringe Services Program (SSP)

Expenditure Start Date: 07/01/2022 Expenditure End Date: 06/30/2023

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

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions.

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

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Footnotes:

III: Expenditure Reports

Table 3b - Syringe Services Program

Expenditure Start Date: 07/01/2022 Expenditure End Date: 06/30/2023

SUPTRS

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

COVID-19[1]

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

ARP[2]

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

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 – March 14, 2023, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions.

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

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Footnotes:

III: Expenditure Reports

Table 3c – Harm Reduction Activities

Expenditure Period Start Date: 07/01/2022 Expenditure Period End Date: 06/30/2023

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

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 - March 14, 2023, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions.

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

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Footnotes:

III: Expenditure Reports

Table 4 - State Agency SUPTRS BG Expenditure Compliance Report

This table provides a description of SUPTRS BG expenditures for authorized activities to prevent and treat SUDs. For detailed instructions, refer to those in WebBGAS. Only one column is to be filled in each year.

Expenditure Period Start Date: 10/1/2020 Expenditure Period End Date: 9/30/2022

Expenditure Category	FY 2021 SA Block Grant Award
1. Substance Use Prevention[1], Treatment, and Recovery	$3,451,115.07
2. Substance Use Primary Prevention	$3,768,123.03
3. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV)[2]	$0.00
4. Tuberculosis Services	$0.00
5. Administration (excluding program/provider level)	$379,959.90
Total	**$7,599,198.00**

[1]Prevention other than Primary Prevention

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

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Footnotes:

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

Resource development expenditures are coded within proper category.

III: Expenditure Reports

SUPTRS BG Table 5a - Primary Prevention Expenditures

The state or jurisdiction must complete SUPTRS BG Table 5a. There are six primary prevention strategies typically funded by principal agencies administering the SUPTRS BG. Expenditures within each of the six strategies or Institute of Medicine Model (IOM) should be directly associated with the cost of completing the activity or task. For example, information dissemination may include the cost of developing pamphlets, the time of participating staff and/or the cost of public service announcements, etc. If a state plans to use strategies not covered by these six categories or the state is unable to calculate expenditures by strategy, please report them under "Other" in Table 5a.

Expenditure Period Start Date: 10/1/2020 Expenditure Period End Date: 9/30/2022

Strategy	IOM Target	Substance Use Block Grant	Other Federal	State	Local	Other
Information Dissemination	Selective					
Information Dissemination	Indicated					
Information Dissemination	Universal	$500,413.54	$189,054.29			
Information Dissemination	Unspecified					
Information Dissemination	**Total**	**$500,413.54**	**$189,054.29**	**$0.00**	**$0.00**	**$0.00**
Education	Selective	$62,551.69				
Education	Indicated					
Education	Universal	$218,930.93	$190,157.29			
Education	Unspecified					
Education	**Total**	**$281,482.62**	**$190,157.29**	**$0.00**	**$0.00**	**$0.00**
Alternatives	Selective					
Alternatives	Indicated					
Alternatives	Universal	$31,275.85	$13,503.89			
Alternatives	Unspecified					
Alternatives	**Total**	**$31,275.85**	**$13,503.89**	**$0.00**	**$0.00**	**$0.00**
Problem Identification and Referral	Selective	$1,563,792.33	$15,402.76			
Problem Identification and Referral	Indicated	$93,827.54	$9,605.02			
Problem Identification and Referral	Universal		$42,511.63			
Problem Identification and Referral	Unspecified					
Problem Identification and Referral	**Total**	**$1,657,619.87**	**$67,519.41**	**$0.00**	**$0.00**	**$0.00**

Community-Based Process	Selective					
Community-Based Process	Indicated					
Community-Based Process	Universal	$312,758.47	$408,582.52			
Community-Based Process	Unspecified					
Community-Based Process	**Total**	**$312,758.47**	**$408,582.52**	**$0.00**	**$0.00**	**$0.00**
Environmental	Selective					
Environmental	Indicated					
Environmental	Universal	$344,034.30	$162,046.53			
Environmental	Unspecified					
Environmental	**Total**	**$344,034.30**	**$162,046.53**	**$0.00**	**$0.00**	**$0.00**
Section 1926 (Synar)-Tobacco	Selective					
Section 1926 (Synar)-Tobacco	Indicated					
Section 1926 (Synar)-Tobacco	Universal			$52,917.00		
Section 1926 (Synar)-Tobacco	**Total**	**$0.00**	**$0.00**	**$52,917.00**	**$0.00**	**$0.00**
Other	Universal Direct					
Other	Universal Indirect					
Other	Selective					
Other	Indicated					
Other	**Total**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
	Grand Total	**$3,127,584.65**	**$1,030,863.93**	**$52,917.00**		

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

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

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Footnotes:

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

Resource development expenditures are not within this form.

III: Expenditure Reports

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

The purpose of the first table is for the state or jurisdiction to identify the substance and/or categories of substances it identified through its needs assessment and then addressed with primary prevention set-aside dollars from the FY 2021 SUPTRS BG NoA. The purpose of the second table is to identify each special population the state or jurisdiction selected as a priority for primary prevention set-aside expenditures.

Expenditure Period Start Date: 10/1/2020 Expenditure Period End Date: 9/30/2022

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

Rural	☐
Other Underserved Racial and Ethnic Minorities	☐

Footnotes:

III: Expenditure Reports

Table 6 - Non Direct Services/System Development

Expenditure Period Start Date: 10/1/2020 Expenditure Period End Date: 9/30/2022

Activity	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]
1. Information Systems	$16,042.95	$60,902.09	$0.00
2. Infrastructure Support	$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$168,211.53	$0.00	$0.00
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$94,832.53	$76,122.88	$0.00
6. Research and Evaluation	$0.00	$212,842.79	$0.00
7. Training and Education	$197,837.20	$290,670.61	$0.00
8. Total	**$476,924.21**	**$640,538.37**	**$0.00**

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

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Footnotes:

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

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

III: Expenditure Reports

Table 7 - Statewide Entity Inventory

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

Expenditure Period Start Date: 10/01/2020 Expenditure Period End Date: 9/30/2022

										Source of Funds Substance Use Block Grant							
	Entity Number	I-BHS ID (formerly I-SATS)	ⓘ	Area Served (Statewide or SubState Planning Area)	Provider / Program Name	Street Address	City	State	Zip	A. All SUPTRS BG Funds	B. Prevention (other than primary prevention) and Treatment Services	C. Pregnant Women and Women with Dependent Children	D. Primary Prevention	E. Early Intervention Services for HIV	F. Syringe Services Program	G[1]. Opioid Treatment Programs (OTPs)	H. Office-based opioid treatment (OBOTs)
	2NDA	N/A	✗	Statewide	2ND Act	100 Davol Square. Suite 100	Providence	RI	02903	$9,686.22	$9,686.22	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	BRD1	RI750156	✗	Statewide	Bridgemark	2020 Elmwood Avenue	Warwick	RI	02888	$59,256.04	$59,256.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	RI100279	RI100279	✗	Statewide	Coastland EAP	120 Centerville Road Center Point Office Park	Warwick	RI	02886	$1,601,710.86	$0.00	$0.00	$1,601,710.86	$0.00	$0.00	$0.00	$0.00
	RI100043	RI100043	✓	Statewide	Community Care Alliance	P.O. Box 1700	Woonsocket	RI	02895	$109,879.99	$109,879.99	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	RI100589	RI100589	✓	Statewide	East Bay Center Inc	2 Old County Road	Barrington	RI	02806	$115,478.33	$115,478.33	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	GMF1	RI100568	✓	Statewide	Galilee Mission Inc	P.O. Box 459	Narragansett	RI	02882	$2,915.96	$2,915.96	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	TRI3	RI100220	✗	Statewide	Gateway Healthcare - Womens Residential	Gateway Healthcare 1443 Hartford Avenue	Johnston	RI	02919	$4,686.92	$4,686.92	$4,686.92	$0.00	$0.00	$0.00	$0.00	$0.00
	N/A	N/A	✗	Statewide	Horizon Health Partners	975 Waterman Ave	East Providence	RI	02914	$987,282.88	$987,282.88	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	PSN1	N/A	✗	Statewide	Parent Support Network	535 Centerville Road	Warwick	RI	02896	$260,975.51	$260,975.51	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	N/A	N/A	✗	Statewide	RISAPA Community TASK Forces	14 Harrington Road	Cranston	RI	02920	$1,525,873.79	$0.00	$0.00	$1,525,873.79	$0.00	$0.00	$0.00	$0.00
	TPC4	RI900991	✗	Statewide	The Providence Center - Long Term Care	c/o The Providence Center 530 North Main Street	Providence	RI	02904	$209,729.32	$209,729.32	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	RI100584	RI100584	✗	Statewide	The Providence Center - Peers	1070 Main Street	Pawtucket	RI	02860	$644,507.85	$644,507.85	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	RI100865	RI100865	✗	Statewide	The Providence Center - Plain Street	1002 Broad Street	Central Falls	RI	02863	$60,638.95	$60,638.95	$60,638.95	$0.00	$0.00	$0.00	$0.00	$0.00
	TPCRCCProv	N/A	✗	Statewide	The Providence Center - Providence RCC	300 Reservoir Ave	Providence	RI	02907	$378,095.79	$378,095.79	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	TPCRCCWar	N/A	✗	Statewide	The Providence Center - Warwick RCC	890 Centerville Road	Providence	RI	02886	$131,057.11	$131,057.11	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total										$6,101,775.52	$2,974,190.87	$65,325.87	$3,127,584.65	$0.00	$0.00	$0.00	$0.00

*** Indicates the imported record has an error.**

Note: [1]42 CFR 8.12: Federal Opioid Treatment Standards (OTP) providers only
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Footnotes:

information taken from state's accounts payable database and separated by service type and contract.

Resource development expenditures are not part of this form.

III: Expenditure Reports

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

This Maintenance of Effort table provides a description of non-federal state expenditures for authorized activities to prevent and treat substance use and provide recovery services flowing through the Single State Agency (SSA) during the state fiscal year immediately preceding the federal fiscal year for which the state is applying for funds. Dates given are for the FFY 2024 SUPTRS BG Report. For the FFY 2025 SUPTRS BG report, please increase each year by one. For detailed instructions, see those in BGAS.

Expenditure Period Start Date: 7/1/2022 Expenditure Period End Date: 06/30/2023

Total Single State Agency (SSA) Expenditures for Substance Abuse Prevention and Treatment		
Period **(A)**	**Expenditures** **(B)**	**B1(2021) + B2(2022)** **2** **(C)**
SFY 2021 (1)	$9,647,178.82	
SFY 2022 (2)	$9,968,911.69	$9,808,045.26
SFY 2023 (3)	$11,237,818.47	

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

SFY 2021	Yes	X	No
SFY 2022	Yes	X	No
SFY 2023	Yes	X	No

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

Yes No X

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

If yes, SFY:

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

Yes No

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

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

Please provide a description of the amounts and methods used to calculate the total Single State Agency (SSA) expenditures for substance use disorder prevention and treatment 42 U.S.C. §300x-30.
Pulled all substance use claims from our licensed SUD providers, all OTP/methadone claims, and calculated the state share of the paid amount of those claims. Also included are state administrative dollars.

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Footnotes:

III: Expenditure Reports

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

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

Expenditure Period Start Date: 7/1/2022 Expenditure Period End Date: 06/30/2023

Base

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

Maintenance

Period	Total Women's Base (A)	Total Expenditures (B)	Expense Type
SFY 2021		$ 2,135,019.00	
SFY 2022		$ 3,108,857.79	
SFY 2023		$ 4,188,119.70	(•) Actual ( ) Estimated
Enter the amount the State plans to expend in SFY 2024 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Section III: Table 8b – Expenditures for Services to Pregnant Women and Women with Dependent Children, Base, Total Women's Base (A) for Period of (SFY 1994)): $ 4,188,119.70;			

Please provide a description of the amounts and methods used to calculate the base and, for 1994 and subsequent fiscal years, report the Federal and State expenditures for such services for services to pregnant women and women with dependent children as required by 42 U.S.C. §300x-22(b)(1).
This amount is a combination of expenditures for the
division via contracts (federal and state dollars), as well as
Medicaid claims for programs that meet the criteria for
women's services.

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

IV: Population and Services Reports

Table 9 - Prevention Strategy Report

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

Expenditure Period Start Date: 10/1/2020 Expenditure Period End Date: 9/30/2022

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Children of People who Misuse Substances	**1. Information Dissemination**	
	1. Clearinghouse/information resources centers	
	2. Resources directories	
	3. Media campaigns	
	4. Brochures	
	5. Radio and TV public service announcements	
	6. Speaking engagements	
	7. Health fairs and other health promotion, e.g., conferences, meetings, seminars	
	2. Education	
	1. Parenting and family management	
	2. Ongoing classroom and/or small group sessions	
	4. Education programs for youth groups	
	6. Preschool ATOD prevention programs	
	3. Alternatives	
	1. Drug free dances and parties	
	2. Youth/adult leadership activities	
	6. Recreation activities	
	4. Problem Identification and Referral	
	2. Student Assistance Programs	
	5. Community-Based Process	
	1. Community and volunteer training, e.g., neighborhood action training, impactor-training, staff/officials training	
	2. Systematic planning	
	3. Multi-agency coordination and collaboration/coalition	
	4. Community team-building	
	5. Accessing services and funding	

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

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Footnotes:

IV: Population and Services Reports

Table 10a – Treatment Utilization Matrix

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

Expenditure Period Start Date: 7/1/2022 Expenditure Period End Date: 6/30/2023

Level of Care	SUPTRS BG Number of Admissions > Number of Persons Served		COVID-19 Number of Admissions > Number of Persons Served[1]		ARP Number of Admissions > Number of Persons Served[2]		SUPTRS BG Service Costs			COVID-19 Costs[1]			ARP Costs[2]		
	Number of Admissions (A)	Number of Persons Served (B)	Number of Admissions (C)	Number of Persons Served (D)	Number of Admissions (E)	Number of Persons Served (F)	Mean (G)	Median (H)	Standard Deviation (I)	Mean Cost (J)	Median Cost (K)	Standard Deviation (L)	Mean Cost (M)	Median Cost (N)	Standard Deviation (O)
DETOXIFICATION (24-HOUR CARE)															
1. Hospital Inpatient	0	0													
2. Free-Standing Residential	966	267													
REHABILITATION/RESIDENTIAL															
3. Hospital Inpatient	0	0													
4. Short-term (up to 30 days)	57	39													
5. Long-term (over 30 days)	1,634	980													
AMBULATORY (OUTPATIENT)															
6. Outpatient	1,484	1,242													
7. Intensive Outpatient	479	355													
8. Detoxification	1	1													
OUD MEDICATION ASSISTED TREATMENT															
9. MOUD Medication-Assisted Detoxification	5	3													
10. MOUD Medication-Assisted Treatment Outpatient	1,555	1,230													

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

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 – March 14, 2023, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current NoA Terms and Conditions.

[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/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025.

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

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Footnotes:

IV: Population and Services Reports

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

This table provides an aggregate profile of the unduplicated persons that received recovery support services funded through the SUPTRS BG by age and gender identity.

Expenditure Period Start Date: 07/01/2022 Expenditure Period End Date: 06/30/2023

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

[1]Age category 0-5 years is not applicable.

	Age 13-17							Age 18-20						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	0	0	0	0	0	0	0	4	15	1	0	0	0	0
Peer-Led Support Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Housing	0	0	0	0	0	0	0	1	1	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	Age 21-24							Age 25-44						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	0	0	0	0	0	0	0	111	155	1	3	0	4	0
Peer-Led Support Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Housing	2	12	0	0	0	0	0	175	364	0	0	0	0	18
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	Age 45-64							Age 65-74						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	101	188	0	0	0	1	1	8	24	0	0	0	0	0
Peer-Led Support Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Housing	130	318	0	0	0	0	41	7	14	0	0	0	0	20
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	Age 75+							Age Not Available						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Support Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Housing	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	Total						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
Peer-to-Peer Support Individual	**224**	**382**	**2**	**3**	**0**	**5**	**1**
Peer-Led Support Group	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Peer-Led Training or Peer Certification Activity	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Recovery Housing	**317**	**709**	**0**	**0**	**0**	**0**	**79**
Recovery Support Service Childcare Fee or Family Caregiver Fee	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Recovery Support Service Transportation	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Secondary School, High School, or Collegiate Recovery Program Service or Activity	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	0	0	0	0	0	0	0
Comments on Data (Age):	Due to the data collection tool for "peer-to-peer support individuals" ages 21-24 were reported in the 18-20 age group and ages 75+ were reported in the 65-74 age group in the matrix above.						
Comments on Data (Gender):	Data on recovery housing clients is limited and can only be broken down into male and female.						
Comments on Data (Overall):	A note from BHDDH's lead on peer based recovery support services: We are not able to submit any data on this table because our funded partners do not collect and report data to the level of specificity asked for. We do have information about our funded peer services but it is not to this level of detail. It was startling to see all this new information being asked for with no warning. We can change our reporting requirements going forward but there is no way for us to get this level of information about services that have already						

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A note from BHDDH's lead on peer based recovery support services: We are not able to submit any data on this table because our funded partners do not collect and report data to the level of specificity asked for. We do have information about our funded peer services but it is not to this level of detail. It was startling to see all this new information being asked for with no warning. We can change our reporting requirements going forward but there is no way for us to get this level of information about services that have already happened. States need advanced notice of data collection changes so we can create new data collection and reporting tools and prepare funded partners to use them.

IV: Population and Services Reports

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

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

Expenditure Period Start Date: 07/01/2022 Expenditure Period End Date: 06/30/2023

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

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

	Total								American Indian or Alaska Native							
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Total	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years[1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	12	12	0	0	0	0	0	24	0	0	0	0	0	0	0
18-20 years	24	51	0	0	0	0	0	75	0	0	0	0	0	0	0
21-24 years	122	220	0	0	0	0	0	342	1	2	0	0	0	0	0
25-44 years	1,748	3,314	0	0	0	0	0	5,062	8	20	0	0	0	0	0
45-64 years	772	1,830	0	0	0	0	0	2,602	3	12	0	0	0	0	0
65-74 years	20	56	0	0	0	0	0	76	0	0	0	0	0	0	0
75+ years	0	2	0	0	0	0	0	2	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	2,698	5,485	0	0	0	0	0	8,183	12	34	0	0	0	0	0
Pregnant Women	60								0						

Number of Persons Served who were admitted in a Period Prior to the 12-month reporting Period	7044
Number of Persons Served outside of the levels of care described on SUPTRS BG Table 10	0

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

Yes No

Comments on Data (Race)	
Comments on Data (Gender)	Data on gender identity is limited and not included. We are getting a new data collection system soon and plan to align gender identity categories with those listed in these tables.
Comments on Data (Overall)	Data on sexual orientation is limited. Queer/pansexual/or questioning is where we input our data for 'Other' sexual orientation, and Something Else? is where we put our unknown sexual orientation data. We are getting a new data collection system soon and plan to align sexual orientation categories with those listed below.

[1]Age category 0-5 years is not applicable.

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

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

6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	1	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	4	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	5	16	0	0	0	0	0
25-44 years	8	9	0	0	0	0	0	66	214	0	0	0	0	0
45-64 years	1	4	0	0	0	0	0	35	93	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	2	1	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**9**	**13**	**0**	**0**	**0**	**0**	**0**	**109**	**328**	**0**	**0**	**0**	**0**	**0**
Pregnant Women	1							3						

[1]Age category 0-5 years is not applicable.

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

	Native Hawaiian or Other Pacific Islander							White						
	Female	**Male**	**Transgender (Trans Woman)**	**Transgender (Trans Man)**	**Gender Non-Conforming**	**Other**	**Not Available**	**Female**	**Male**	**Transgender (Trans Woman)**	**Transgender (Trans Man)**	**Gender Non-Conforming**	**Other**	**Not Available**
0-5 years[1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	3	5	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	11	14	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	45	63	0	0	0	0	0
25-44 years	1	2	0	0	0	0	0	685	1,086	0	0	0	0	0
45-64 years	2	1	0	0	0	0	0	307	660	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	7	24	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**3**	**3**	**0**	**0**	**0**	**0**	**0**	**1,058**	**1,853**	**0**	**0**	**0**	**0**	**0**
Pregnant Women	0							21						

[1]Age category 0-5 years is not applicable.

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

	Some Other Race							More than One Race Reported						
	Female	**Male**	**Transgender (Trans Woman)**	**Transgender (Trans Man)**	**Gender Non-Conforming**	**Other**	**Not Available**	**Female**	**Male**	**Transgender (Trans Woman)**	**Transgender (Trans Man)**	**Gender Non-Conforming**	**Other**	**Not Available**
0-5 years[1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	1	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	1	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	1	1	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	26	30	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	6	12	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0

75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**33**	**45**	**0**	**0**	**0**	**0**	**0**
Pregnant Women	0							1						

[1]Age category 0-5 years is not applicable.

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

	Race Not Available							Not Hispanic or Latino						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years[1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	2	0	0	0	0	0	0	4	5	0	0	0	0	0
18-20 years	1	6	0	0	0	0	0	9	20	0	0	0	0	0
21-24 years	9	28	0	0	0	0	0	54	81	0	0	0	0	0
25-44 years	80	295	0	0	0	0	0	794	1,368	0	0	0	0	0
45-64 years	32	133	0	0	0	0	0	358	790	0	0	0	0	0
65-74 years	1	3	0	0	0	0	0	9	25	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**125**	**465**	**0**	**0**	**0**	**0**	**0**	**1,228**	**2,290**	**0**	**0**	**0**	**0**	**0**
Pregnant Women	4							26						

[1]Age category 0-5 years is not applicable.

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

	Hispanic or Latino							Hispanic or Latino Origin Not Available						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years[1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	2	1	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	3	6	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	7	29	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	79	290	0	0	0	0	0	1	0	0	0	0	0	0
45-64 years	28	125	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	1	3	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**120**	**454**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**
Pregnant Women	4							0						

[1]Age category 0-5 years is not applicable.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use[1]

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

	Total	American Indian or Alaska Native

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

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 – March 14, 2023, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current NoA Terms and Conditions.

[2]Age category 0-5 years is not applicable.

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

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

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

[1]Age category 0-5 years is not applicable.

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

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

[1]Age category 0-5 years is not applicable.

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

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

[1]Age category 0-5 years is not applicable.

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

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

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

[1]Age category 0-5 years is not applicable.

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

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

[1]Age category 0-5 years is not applicable.

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

	Sexual Orientation								
A. Age	B. Straight or Heterosexual	C. Homosexual (Gay or Lesbian)	D. Bisexual	E. Queer	F. Pansexual	G. Questioning	H. Asexual	I. Other	J. Not Available
0-5 years[1]	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0
13-17 years	9	0	2	0	0	0	0	0	1
18-20 years	25	1	1	0	0	0	0	0	11
21-24 years	132	1	3	0	0	0	0	1	34
25-44 years	1,943	50	63	0	0	0	0	9	467
45-64 years	985	15	19	0	0	0	0	4	278
65-74 years	31	0	0	0	0	0	0	0	7
75+ years	1	0	0	0	0	0	0	0	0
TOTAL	**3,126**	**67**	**88**	**0**	**0**	**0**	**0**	**14**	**798**

[1]Age category 0-5 years is not applicable.

Footnotes:

IV: Population and Services Reports

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

Expenditure Period Start Date: 7/1/2022 Expenditure Period End Date: 6/30/2023

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

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:
Rhode Island was not a designated state in FY23.

IV: Population and Services Reports

Table 13 - Charitable Choice – Required

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

Expenditure Period Start Date: 7/1/2022 Expenditure Period End Date: 6/30/2023

Notice to Program Beneficiaries - Check all that apply:

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

Referrals to Alternative Services - Check all that apply:

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

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

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

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

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

Short-term Residential(SR)

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

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	541	622
Total number of clients with non-missing values on employment/student status [denominator]	1,464	1,464
Percent of clients employed or student (full-time and part-time)	37.0 %	42.5 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	1,380
Number of CY 2022 discharges submitted:	1,525
Number of CY 2022 discharges linked to an admission:	1,516
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1,511
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	1,464

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Long-term Residential(LR)

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

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	2	9
Total number of clients with non-missing values on employment/student status [denominator]	201	201
Percent of clients employed or student (full-time and part-time)	1.0 %	4.5 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	192
Number of CY 2022 discharges submitted:	204
Number of CY 2022 discharges linked to an admission:	204
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	202

Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	201

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Outpatient (OP)

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

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	823	908
Total number of clients with non-missing values on employment/student status [denominator]	1,282	1,282
Percent of clients employed or student (full-time and part-time)	64.2 %	70.8 %
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		4,749
Number of CY 2022 discharges submitted:		3,959
Number of CY 2022 discharges linked to an admission:		3,418
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		1,376
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):		1,282

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Intensive Outpatient (IO)

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

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	174	198
Total number of clients with non-missing values on employment/student status [denominator]	338	338
Percent of clients employed or student (full-time and part-time)	51.5 %	58.6 %
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		538
Number of CY 2022 discharges submitted:		382
Number of CY 2022 discharges linked to an admission:		366
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		360

Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	338

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

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

Short-term Residential(SR)

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

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	1,185	1,187
Total number of clients with non-missing values on living arrangements [denominator]	1,495	1,495
Percent of clients in stable living situation	79.3 %	79.4 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	1,380
Number of CY 2022 discharges submitted:	1,525
Number of CY 2022 discharges linked to an admission:	1,516
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1,511
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	1,495

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Long-term Residential(LR)

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

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	194	194
Total number of clients with non-missing values on living arrangements [denominator]	202	202
Percent of clients in stable living situation	96.0 %	96.0 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	192
Number of CY 2022 discharges submitted:	204
Number of CY 2022 discharges linked to an admission:	204
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	202
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	202

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Outpatient (OP)

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

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	1,322	1,321
Total number of clients with non-missing values on living arrangements [denominator]	1,366	1,366
Percent of clients in stable living situation	96.8 %	96.7 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	4,749
Number of CY 2022 discharges submitted:	3,959
Number of CY 2022 discharges linked to an admission:	3,418
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1,376
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	1,366

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Intensive Outpatient (IO)

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

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	338	338
Total number of clients with non-missing values on living arrangements [denominator]	355	355
Percent of clients in stable living situation	95.2 %	95.2 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	538
Number of CY 2022 discharges submitted:	382
Number of CY 2022 discharges linked to an admission:	366
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	360
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	355

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Footnotes:

V: Performance Data and Outcomes

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

Short-term Residential(SR)

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

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	1,178	1,242
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	1,257	1,257
Percent of clients without arrests	93.7 %	98.8 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	1,380
Number of CY 2022 discharges submitted:	1,525
Number of CY 2022 discharges linked to an admission:	1,516
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1,516
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	1,257

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Long-term Residential(LR)

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

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	180	193
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	203	203
Percent of clients without arrests	88.7 %	95.1 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	192
Number of CY 2022 discharges submitted:	204
Number of CY 2022 discharges linked to an admission:	204
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	204

Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	203

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Outpatient (OP)

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

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	1,052	1,083
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	1,111	1,111
Percent of clients without arrests	94.7 %	97.5 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	4,749
Number of CY 2022 discharges submitted:	3,959
Number of CY 2022 discharges linked to an admission:	3,418
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1,406
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	1,111

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Intensive Outpatient (IO)

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

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	236	239
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	243	243
Percent of clients without arrests	97.1 %	98.4 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	538
Number of CY 2022 discharges submitted:	382
Number of CY 2022 discharges linked to an admission:	366
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	365

Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	243

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

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

Short-term Residential(SR)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	560	908
All clients with non-missing values on at least one substance/frequency of use [denominator]	1,515	1,515
Percent of clients abstinent from alcohol	37.0 %	59.9 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		384
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	955	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		40.2 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		524
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	560	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		93.6 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	1,380
Number of CY 2022 discharges submitted:	1,525
Number of CY 2022 discharges linked to an admission:	1,516
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1,516
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	1,515

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Long-term Residential(LR)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	140	168
All clients with non-missing values on at least one substance/frequency of use [denominator]	204	204
Percent of clients abstinent from alcohol	68.6 %	82.4 %

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

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

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

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		129
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	140	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		92.1 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	192
Number of CY 2022 discharges submitted:	204
Number of CY 2022 discharges linked to an admission:	204
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	204
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	204

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Outpatient (OP)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	816	1,041
All clients with non-missing values on at least one substance/frequency of use [denominator]	1,398	1,398
Percent of clients abstinent from alcohol	58.4 %	74.5 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		321
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	582	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		55.2 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		720
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	816	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		88.2 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	4,749
Number of CY 2022 discharges submitted:	3,959
Number of CY 2022 discharges linked to an admission:	3,418
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1,406
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	1,398

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Intensive Outpatient (IO)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	189	263
All clients with non-missing values on at least one substance/frequency of use [denominator]	365	365
Percent of clients abstinent from alcohol	51.8 %	72.1 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		96
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	176	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		54.5 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		167
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	189	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		88.4 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	538
Number of CY 2022 discharges submitted:	382
Number of CY 2022 discharges linked to an admission:	366
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	365
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	365

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

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

Short-term Residential(SR)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	722	859
All clients with non-missing values on at least one substance/frequency of use [denominator]	1,515	1,515
Percent of clients abstinent from drugs	47.7 %	56.7 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		226
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	793	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		28.5 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		633
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	722	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		87.7 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	1,380
Number of CY 2022 discharges submitted:	1,525
Number of CY 2022 discharges linked to an admission:	1,516
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1,516
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	1,515

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Long-term Residential(LR)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	92	96
All clients with non-missing values on at least one substance/frequency of use [denominator]	204	204
Percent of clients abstinent from drugs	45.1 %	47.1 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		42
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	112	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		37.5 %

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

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

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

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	192
Number of CY 2022 discharges submitted:	204
Number of CY 2022 discharges linked to an admission:	204
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	204
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	204

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Outpatient (OP)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	948	873
All clients with non-missing values on at least one substance/frequency of use [denominator]	1,398	1,398
Percent of clients abstinent from drugs	67.8 %	62.4 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		112
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	450	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		24.9 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		761
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	948	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		80.3 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	4,749
Number of CY 2022 discharges submitted:	3,959
Number of CY 2022 discharges linked to an admission:	3,418
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1,406
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	1,398

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Intensive Outpatient (IO)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	227	217
All clients with non-missing values on at least one substance/frequency of use [denominator]	365	365
Percent of clients abstinent from drugs	62.2 %	59.5 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		29
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	138	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		21.0 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		188
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	227	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		82.8 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	538
Number of CY 2022 discharges submitted:	382
Number of CY 2022 discharges linked to an admission:	366
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	365
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	365

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

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

Short-term Residential(SR)

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

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	130	1,252
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	1,369	1,369
Percent of clients participating in self-help groups	9.5 %	91.5 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	82.0 %	
Notes (for this level of care):		
Number of CY 2022 admissions submitted:	1,380	
Number of CY 2022 discharges submitted:	1,525	
Number of CY 2022 discharges linked to an admission:	1,516	
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1,516	
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	1,369	

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Long-term Residential(LR)

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

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	7	17
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	179	179
Percent of clients participating in self-help groups	3.9 %	9.5 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	5.6 %	
Notes (for this level of care):		
Number of CY 2022 admissions submitted:	192	
Number of CY 2022 discharges submitted:	204	

Number of CY 2022 discharges linked to an admission:	204
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	204
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	179

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Outpatient (OP)

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

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	107	102
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	1,261	1,261
Percent of clients participating in self-help groups	8.5 %	8.1 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	-0.4 %	
Notes (for this level of care):		
Number of CY 2022 admissions submitted:	4,749	
Number of CY 2022 discharges submitted:	3,959	
Number of CY 2022 discharges linked to an admission:	3,418	
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1,406	
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	1,261	

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

Intensive Outpatient (IO)

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

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	62	55
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	313	313
Percent of clients participating in self-help groups	19.8 %	17.6 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	-2.2 %	
Notes (for this level of care):		
Number of CY 2022 admissions submitted:	538	

Number of CY 2022 discharges submitted:	382
Number of CY 2022 discharges linked to an admission:	366
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	365
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	313

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

Table 20 - Retention - Length of Stay (in Days) of Clients Completing Treatment

Level of Care	Average (Mean)	25th Percentile	50th Percentile (Median)	75th Percentile
DETOXIFICATION (24-HOUR CARE)				
1. Hospital Inpatient	0	0	0	0
2. Free-Standing Residential	7	4	6	6
REHABILITATION/RESIDENTIAL				
3. Hospital Inpatient	5	4	5	5
4. Short-term (up to 30 days)	31	11	20	32
5. Long-term (over 30 days)	52	16	38	68
AMBULATORY (OUTPATIENT)				
6. Outpatient	116	33	72	133
7. Intensive Outpatient	55	17	34	55
8. Detoxification	2	2	2	2
OUD MEDICATION ASSISTED TREATMENT				
9. OUD Medication-Assisted Detoxification[1]	173	10	162	285
10. OUD Medication-Assisted Treatment Outpatient[2]	176	29	87	242

Level of Care	2022 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
DETOXIFICATION (24-HOUR CARE)		
1. Hospital Inpatient	0	0
2. Free-Standing Residential	1029	1031
REHABILITATION/RESIDENTIAL		
3. Hospital Inpatient	2	2
4. Short-term (up to 30 days)	1525	1516

5. Long-term (over 30 days)	204	204
AMBULATORY (OUTPATIENT)		
6. Outpatient	3959	1409
7. Intensive Outpatient	382	366
8. Detoxification	9	1
OUD MEDICATION ASSISTED TREATMENT		
9. OUD Medication-Assisted Detoxification[1]		8
10. OUD Medication-Assisted Treatment Outpatient[2]		2009

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 5/1/2023]

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

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

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

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

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	**Source Survey Item:** NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from **[DATEFILL]** through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?[Response option: Write in a number between 0 and 30.]" **Outcome Reported:** Percent who reported having used alcohol during the past 30 days.		
	Age 12 - 20 - CY 2020 - 2021		
	Age 21+ - CY 2020 - 2021		
2. 30-day Cigarette Use	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you smoke part or all of a cigarette?[Response option: Write in a number between 0 and 30.]" **Outcome Reported:** Percent who reported having smoked a cigarette during the past 30 days.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
3. 30-day Use of Other Tobacco Products	**Survey Item: NSDUH Questionnaire:** "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you use [other tobacco products][1]?[Response option: Write in a number between 0 and 30.]" **Outcome Reported:** Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (cigars, smokeless tobacco, pipe tobacco).		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
4. 30-day Use of Marijuana	**Source Survey Item: NSDUH Questionnaire:** "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?[Response option: Write in a number between 0 and 30.]" **Outcome Reported:** Percent who reported having used marijuana or hashish during the past 30 days.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
5. 30-day Use of Illicit Drugs Other Than Marijuana	**Source Survey Item: NSDUH Questionnaire:** "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use [any other illicit drug]?[2]" **Outcome Reported:** Percent who reported having used illicit drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, hallucinogens, inhalants, methamphetamine, and misuse of prescription drugs).		
	Age 12 - 17 - CY 2020 - 2021		

	Age 18+ - CY 2020 - 2021		

[1]NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
[2]NSDUH asks separate questions for each illicit drug. The number provided combines responses to all questions about illicit drugs other than marijuana or hashish.
0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

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

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. Perception of Risk From Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk]" **Outcome Reported:** Percent reporting moderate or great risk.		
	Age 12 - 20 - CY 2020 - 2021		
	Age 21+ - CY 2020 - 2021		
2. Perception of Risk From Cigarettes	**Source Survey Item: NSDUH Questionnaire:** "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?[Response options: No risk, slight risk, moderate risk, great risk]" **Outcome Reported:** Percent reporting moderate or great risk.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
3. Perception of Risk From Marijuana	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk]" **Outcome Reported:** Percent reporting moderate or great risk.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

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

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	**Source Survey Item: NSDUH Questionnaire:** "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink. [Response option: Write in age at first use.]" **Outcome Reported:** Average age at first use of alcohol.		
	Age 12 - 20 - CY 2020 - 2021		
	Age 21+ - CY 2020 - 2021		
2. Age at First Use of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?[Response option: Write in age at first use.]" **Outcome Reported:** Average age at first use of cigarettes.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
3. Age at First Use of Tobacco Products Other Than Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product][1]?[Response option: Write in age at first use.]" **Outcome Reported:** Average age at first use of tobacco products other than cigarettes.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
4. Age at First Use of Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?[Response option: Write in age at first use.]" **Outcome Reported:** Average age at first use of marijuana or hashish.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
5. Age at First Use Heroin	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used heroin? [Response option: Write in age at first use.]" **Outcome Reported:** Average age at first use of heroin.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
6. Age at First Misuse of Prescription Pain Relievers Among Past Year Initiates	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [specific pain reliever][2] in a way a doctor did not direct you to use it?"[Response option: Write in age at first use.]" **Outcome Reported:** Average age at first misuse of prescription pain relievers among those who first misused prescription pain relievers in the last 12 months.		

	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		

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

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

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]" **Outcome Reported:** Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2020 - 2021		
2. Perception of Peer Disapproval of Cigarettes	**Source Survey Item: NSDUH Questionnaire:** "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]" **Outcome Reported:** Percent reporting that their friends would somewhat or strongly disapprove.		
	Age 12 - 17 - CY 2020 - 2021		
3. Disapproval of Using Marijuana Experimentally	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]" **Outcome Reported:** Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2020 - 2021		
4. Disapproval of Using Marijuana Regularly	**Source Survey Item: NSDUH Questionnaire:** "How do you feel about someone your age using marijuana once a month or more?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]" **Outcome Reported:** Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2020 - 2021		
5. Disapproval of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]" **Outcome Reported:** Percent somewhat or strongly disapproving.		
	Age 12 - 20 - CY 2020 - 2021		

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

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Perception of Workplace Policy	**Source Survey Item:** NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?[Response options: More likely, less likely, would make no difference]" **Outcome Reported:** Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.		
	Age 15 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		

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

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	**Source:** National Center for Education Statistics, Common Core of Data: *The National Public Education Finance Survey* available for download at **http://nces.ed.gov/ccd/stfis.asp**. **Measure calculation:** Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.		
	School Year 2020		

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

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	**Source:** National Highway Traffic Safety Administration Fatality Analysis Reporting System **Measure calculation:** The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.		
	CY 2021		

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

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	**Source:** Federal Bureau of Investigation Uniform Crime Reports **Measure calculation:** The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.		
	CY 2021		

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

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Youth)	**Source Survey Item:** NSDUH Questionnaire: "Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No] **Outcome Reported:** Percent reporting having talked with a parent.		
	Age 12 - 17 - CY 2020 - 2021		
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12-17)	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" [1][Response options: 0 times, 1 to 2 times, a few times, many times] **Outcome Reported:** Percent of parents reporting that they have talked to their child.		
	Age 18+ - CY 2020 - 2021		

[1]NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

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Table 30 – Substance Use Disorder Primary Prevention NOMs Domain: Retention Measure: Percentage of Youth Seeing, or Listening to a Prevention Message

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use][1]?" **Outcome Reported:** Percent reporting having been exposed to prevention message.		
	Age 12 - 17 - CY 2020 - 2021		

[1]This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context

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

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

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

Tables	A. Reporting Period Start Date	B. Reporting Period End Date
1. Table 31 – Substance Use Disorder Primary Prevention Individual-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2021	12/31/2021
2. Table 32 – Substance Use Disorder Primary Prevention Population-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2021	12/31/2021
3. Table 33 (Optional) – Substance Use Disorder Primary Prevention Number of Persons Served by Type of Intervention	1/1/2021	12/31/2021
4. Table 34 – Substance Use Disorder Primary Prevention Number of Evidence-Based Programs and Strategies by Type of Intervention	1/1/2021	12/31/2021
5. Table 35 – Total Substance Use Disorder Primary Prevention Number of Evidence Based Programs/Strategies and Total SUPTRS BG Dollars Spent on Substance Use Disorder Primary Prevention Evidence-Based Programs/Strategies	10/1/2020	9/30/2022

General Questions Regarding Prevention NOMS Reporting

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

In Rhode Island we use the Mosaix IMPACT prevention data collection system to collect all prevention related data.

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

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

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

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

Category	Total
A. Age	**5,090**
0-5	1
6-12	182
13-17	4,642
18-20	265
21-24	
25-44	
45-64	
65-74	
75 and Over	
Age Not Known	
B. Gender	**5,090**
Male	1,965
Female	3,019
Trans man	
Trans woman	
Gender non-conforming	31
Other	75
C. Race	**5,090**
White	3,619
Black or African American	596
Native Hawaiian/Other Pacific Islander	27

Asian	89
American Indian/Alaska Native	109
More Than One Race (not OMB required)	263
Race Not Known or Other (not OMB required)	387
D. Ethnicity	**5,090**
Hispanic or Latino	1,199
Not Hispanic or Latino	3,502
Ethnicity Unknown	389

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

Category	Total
A. Age	**227364**
0-5	1016
6-12	1427
13-17	119994
18-20	50629
21-24	1006
25-44	6339
45-64	11371
65-74	2150
75 and Over	8890
Age Not Known	24542
B. Gender	**227364**
Male	86446
Female	93945
Trans man	
Trans woman	
Gender non-conforming	38419
Other	8554
C. Race	**227364**
White	143870
Black or African American	8061
Native Hawaiian/Other Pacific Islander	54

Asian	4072
American Indian/Alaska Native	743
More Than One Race (not OMB required)	4891
Race Not Known or Other (not OMB required)	65673
D. Ethnicity	**227364**
Hispanic or Latino	17247
Not Hispanic or Latino	148508
Ethnicity Unknown	61609

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

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

Intervention Type	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct		N/A
2. Universal Indirect	N/A	
3. Selective		N/A
4. Indicated		N/A
5. Total	**0**	**$0.00**
Number of Persons Served[1]	**5,090**	**227,364**

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

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

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

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

The Selective and Indicated Evidence-Based program Project Success was previously on the Federal List of Registry. We have worked extensively with the developer and our evaluator to ensure fidelity. All Universal Direct and Indirect programs were found on the previous Federal List of Registry. We consult with our evaluator on the validity of them being and EBP. We understand that the inclusion on the Federal Registry itself does not constitute status of an Evidence-Based program. However, the selected EBPs have a long evaluation history, there were listed on the previous version of the NREPP.

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

Mosaix IMPACT prevention data collection system and provider reports.

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

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

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

	Total Number of Evidence-Based Programs/Strategies for IOM Category Below	Total Substance Use Block Grant Dollars Spent on evidence-based Programs/Strategies
Universal Direct	Total # 14	$828,987.07
Universal Indirect	Total # 20	$791,305.84
Selective	Total # 1	$1,884,061.52
Indicated	Total # 1	$263,768.61
Unspecified	Total #	
	Total EBPs: 36	Total Dollars Spent: $3,768,123.04

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Expenditures derived from state's accounting system.

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Prevention Attachments

Submission Uploads

FFY 2024 Prevention Attachment Category A:

File	Version	Date Added
(RI) FFY 2024 - CategoryA v1.pdf	1	10/26/2023 8:52:05 AM

FFY 2024 Prevention Attachment Category B:

File	Version	Date Added
(RI) FFY 2024 - CategoryB v1.pdf	1	10/26/2023 8:53:02 AM

FFY 2024 Prevention Attachment Category C:

File	Version	Date Added

FFY 2024 Prevention Attachment Category D:

File	Version	Date Added

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Footnotes:

State of Rhode Island

Final

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 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 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. Over the next 18 months the RPTF will use 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.

Partnership 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 funded to 20 communities that have been identified as high need based on a selected set of indicators. The identified communities are Burrillville, Bristol, Central Falls, Charlestown, Cranston, East Greenwich, East Providence, Hopkinton, Johnston, Lincoln, Middletown, Narragansett, Newport, North Kingstown, North Providence, Portsmouth, Richmond, Warren, Warwick, 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 PEIPT 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 in institutionalized data-driven planning and decision making relevant to substance use/abuse and mental illness across Rhode Island. As such, the SEOW operates within the outcomes-based prevention framework, aiming to integrate prevalence and incidence data with risk and protective factors data into its decision-making process and policy-making at the state and community level.

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), Partnership 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 rats 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 2017 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 2017 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 (2017): A State Epidemiologic Profile ("2017 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 2017 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 2017 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

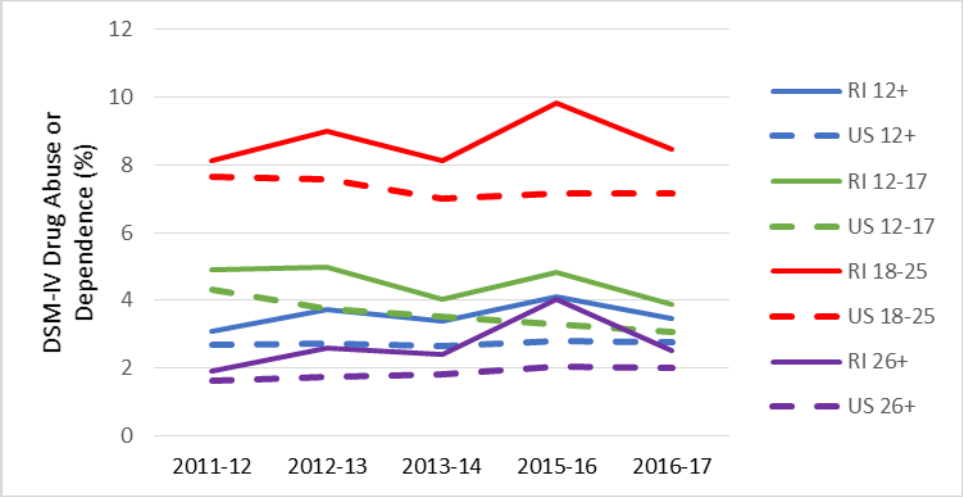
OBJECTIVE: The BHDDH 2019-2024 Strategic Plan contains the following objective related to overdose prevention: By December 2022, 100% of RI communities will sustain at least one activity promoting safer disposal practice previously funded by discretionary grants (Count It, Lock It, Drop media campaign: 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 2017 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 area where we collaborate

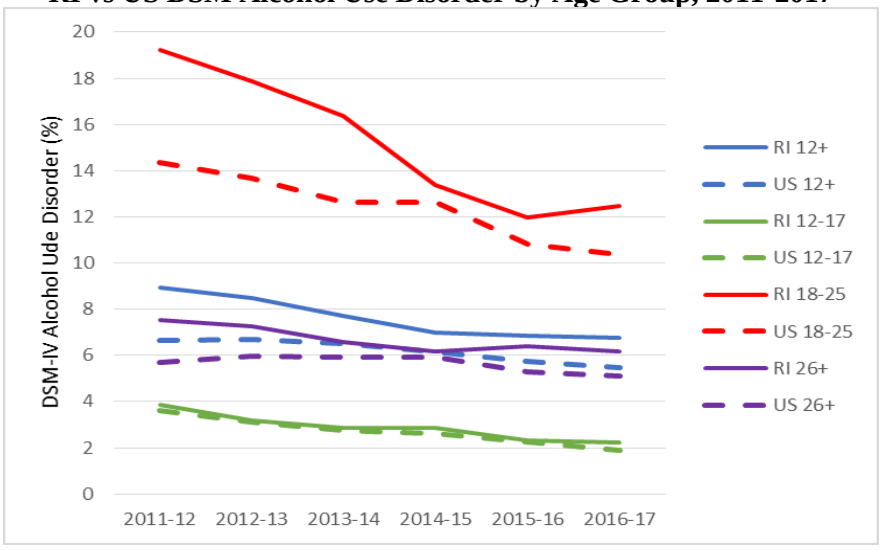
While diagnosis of substance use disorder as defined by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) diagnoses of substance use disorder are potentially changeable with primary prevention strategies, it will take considerably longer than the time frame covered in this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

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



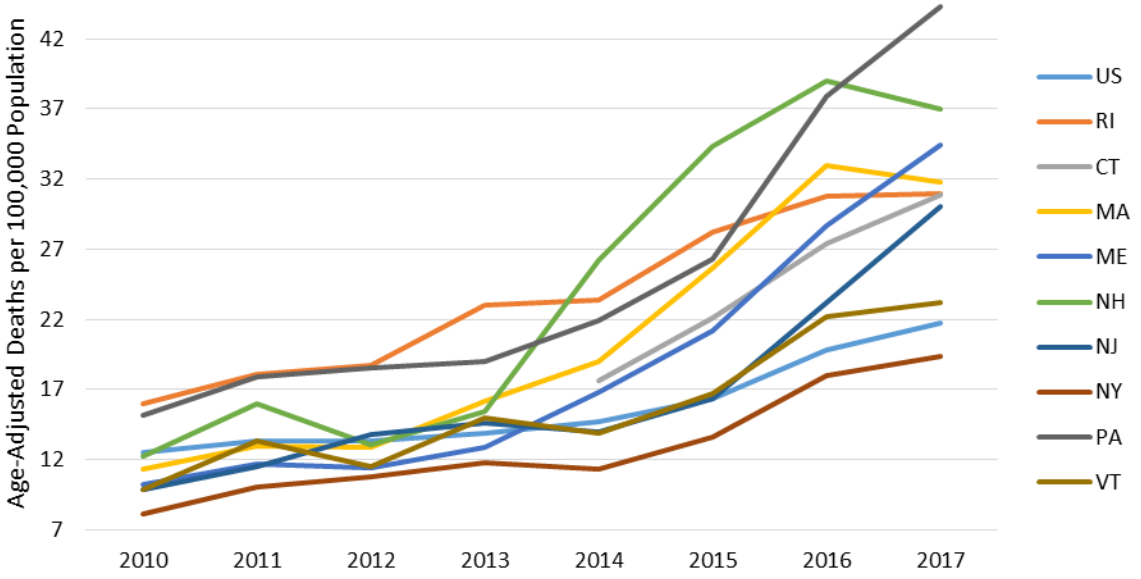
Source: National Survey on Drug Use and Health (NSDUH). **Note:** No data available for 2014-2015.

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



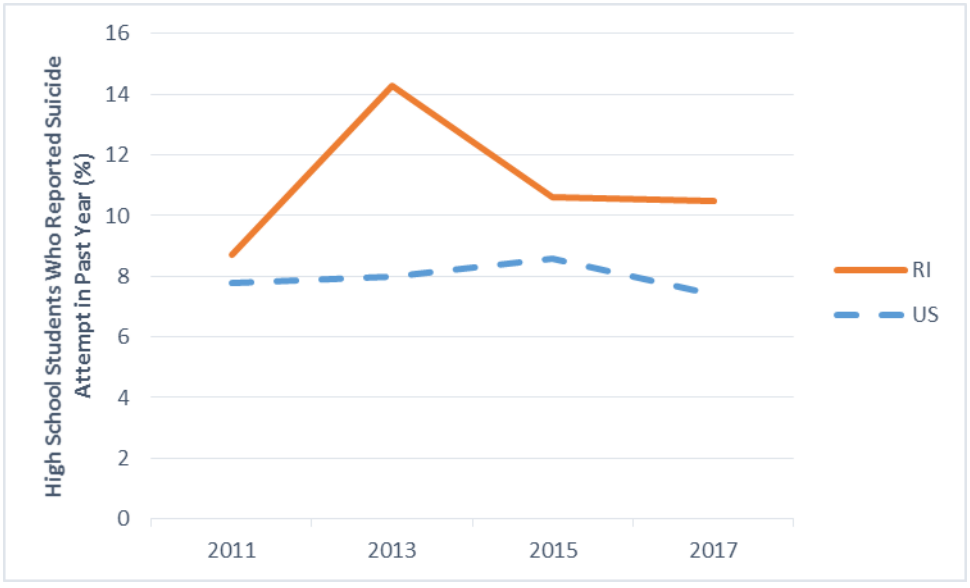
Source: National Survey on Drug Use and Health (NSDUH). ***Note:*** *Indicator name changed from Alcohol Abuse or Dependence to Alcohol Use Disorder in 2014-15.*

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. **2017 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 2019-2024 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 2017 State Epidemiological Profile as described below.

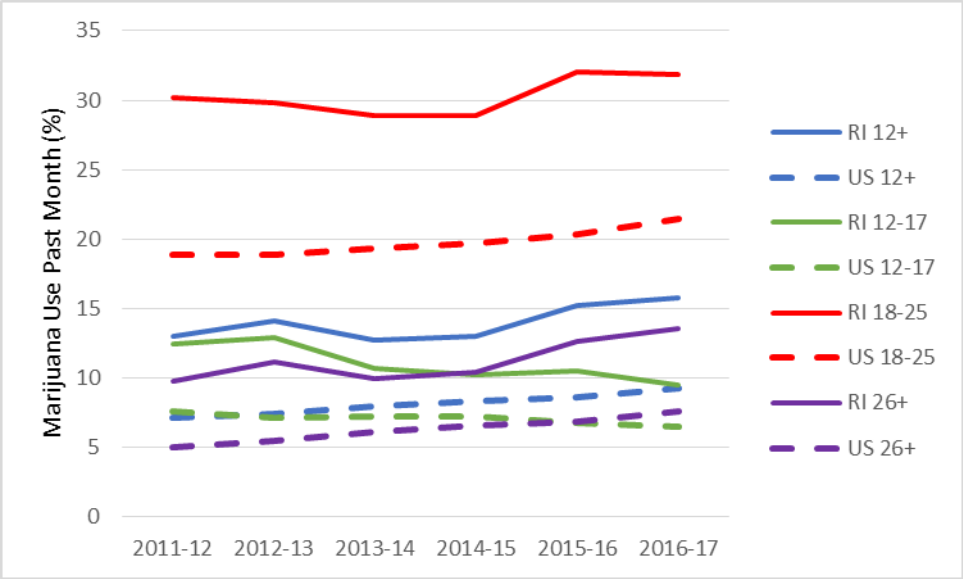
[1] Please note that the 2013 percentages reported in the chart above are believed to be an anomaly based on the RI Department of Health's review of other data for the same time frame

Strategies to support this objective are: (1) provide funding to Regional Prevention Task Forces to use information dissemination strategies to increase 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).

Regarding findings related to youth marijuana use: relevant tables from the 2017 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 to 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

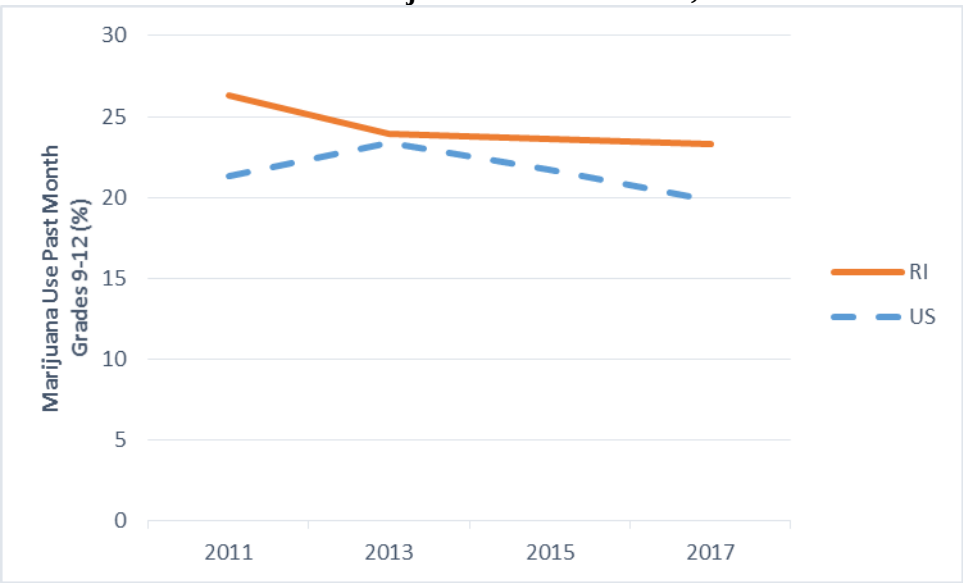


Source: National Survey on Drug Use and Health (NSDUH)

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



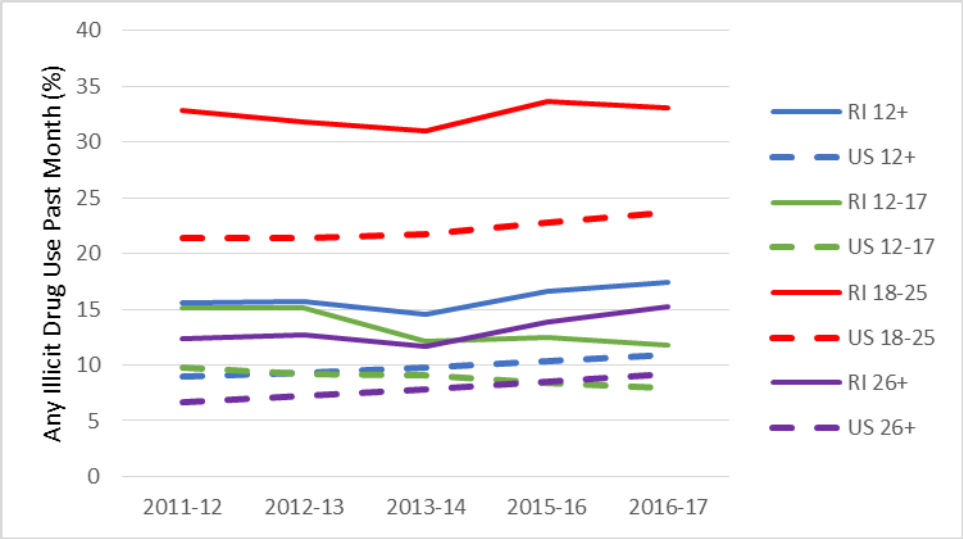
Source: Youth Risk Behavior Survey, Centers for Disease Control

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)

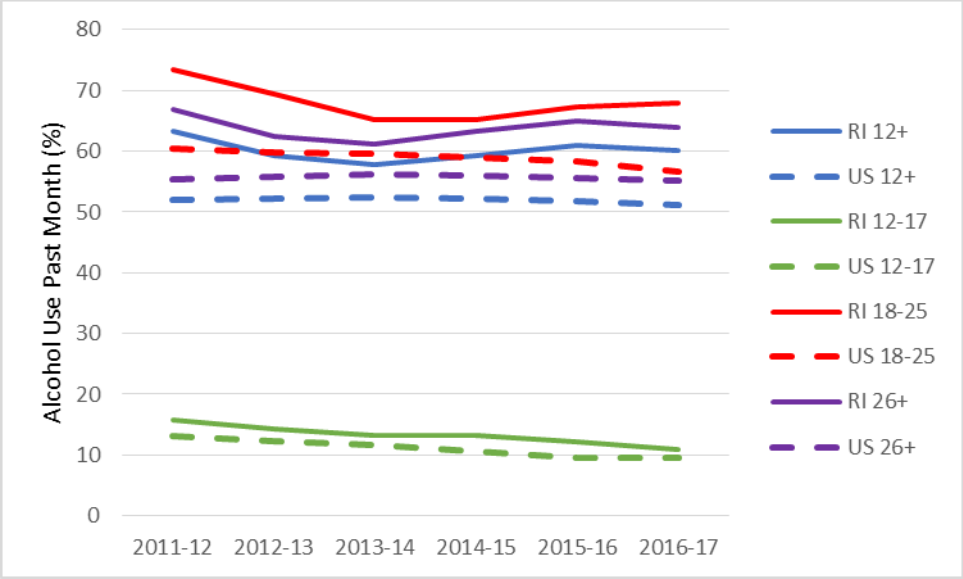
Underage Drinking and Past 30-Day Use Among Young Adults 18-25

OBJECTIVE: The BHDDH 2019-2024 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 2017 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 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.

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.

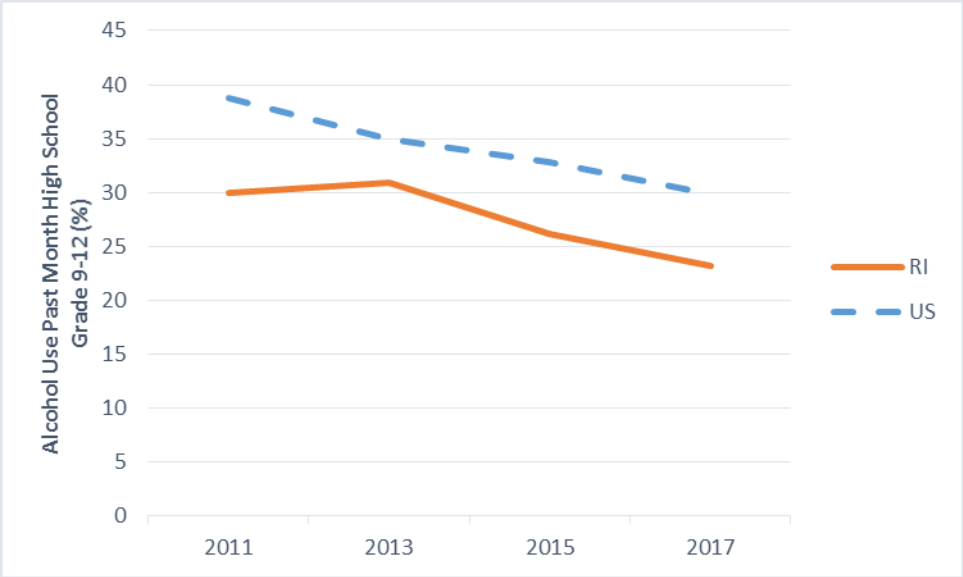
Alcohol Use Past Month by Age Group, 2011-2017



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

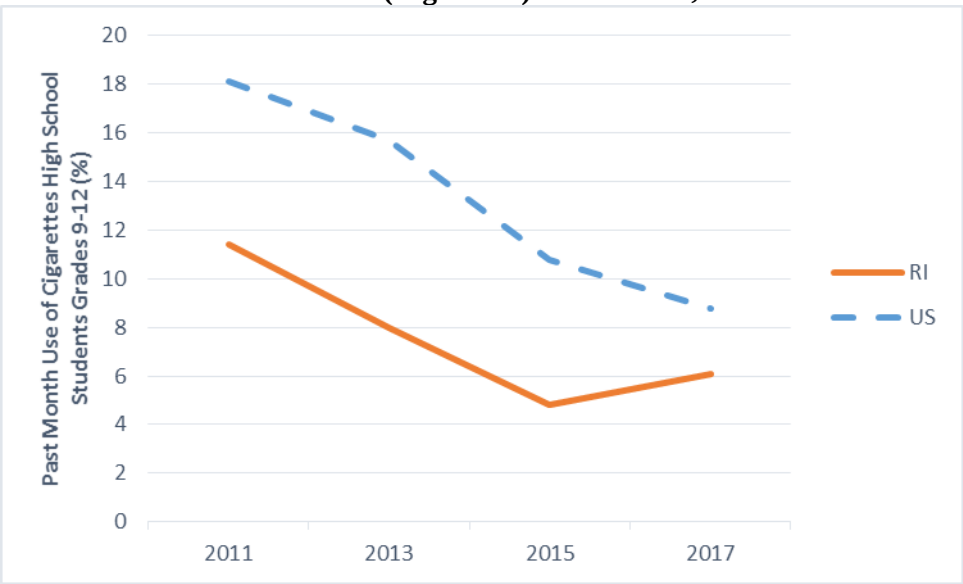
Youth Tobacco Use

OBJECTIVE: The BHDDH 2019-2024 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 increased compliance checks. This priority objective is supported by data contained in the 2017 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 cigarettes 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.

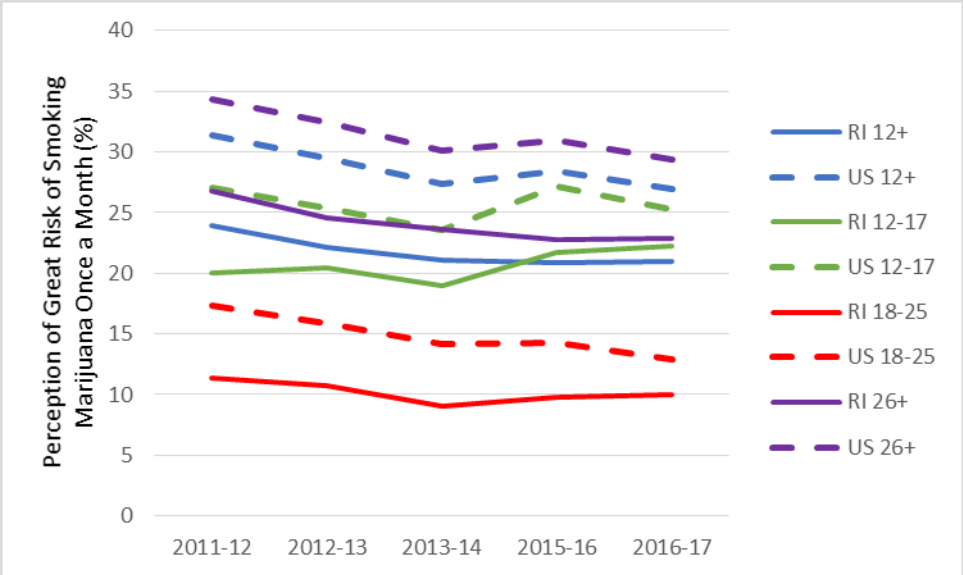
BHDDH provides funds through the Substance Abuse Prevention and Treatment Block Grant to RI communities to implement strategies to address these risk and protective factors. In addition, twenty Rhode Island communities are currently receiving funding through the Partnerships for Success II (PFS II) grant 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

a. 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.*

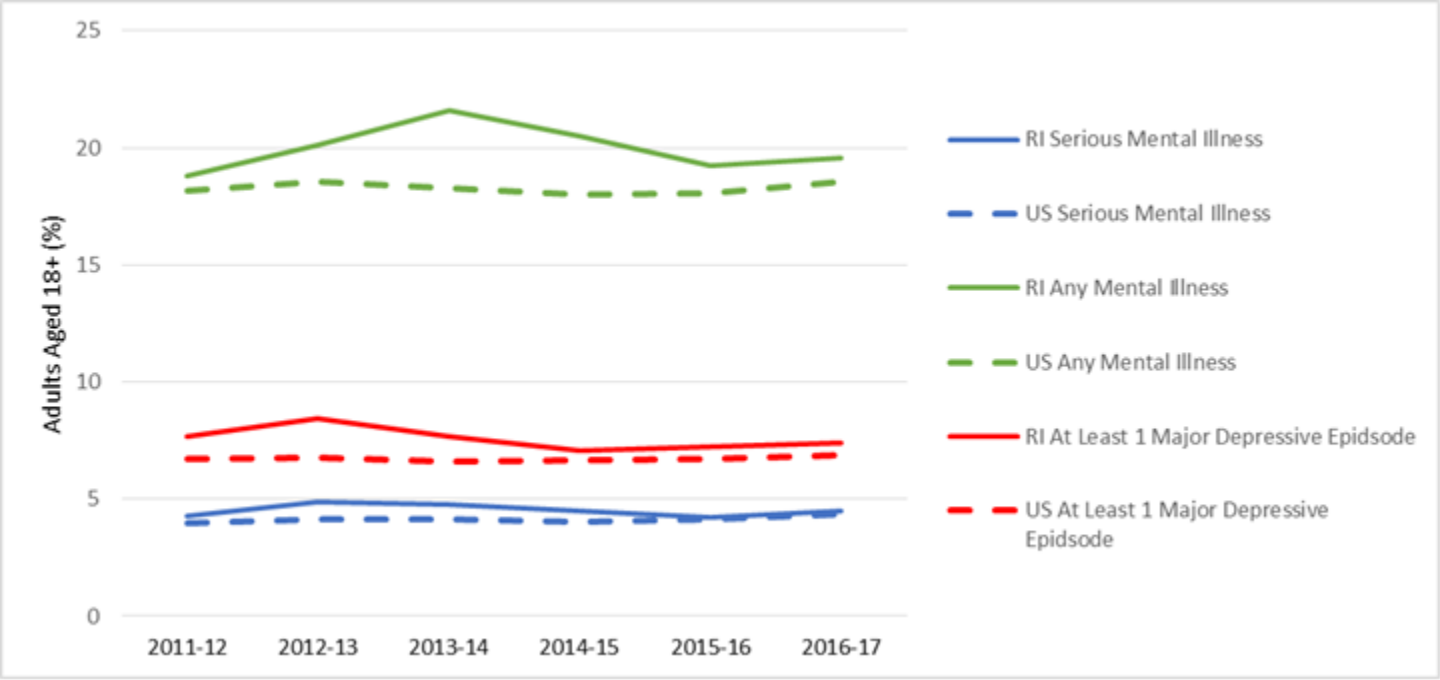
b. Access and Availability of Substances with Age Based or Other Conditional Use Restrictions

Use of alcohol and tobacco is restricted to adults, which is defined as 21 for alcohol and 18 for tobacco. Currently, marijuana possession and use is illegal in Rhode Island. In the case of medical marijuana, there may be some circumstances in which an underage individual has a medical marijuana card permitting possession or use of marijuana for medical purposes. Funded entities are implementing environmental change strategies (policy/ordinance change; enforcement strategies: and enforcement strategies to curtail illegal retail or social access to targeted substances).

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

D. MENTAL HEALTH

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



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

RI has fared worse than most states in the region across all adult mental health indicators including past year serious mental illness, past year any mental illness, and having had at least one major depressive episode in the past year. RI had also consistently fared worse than the national average across adult mental health indicators. In 2013-14, RI had the highest prevalence in the northeast region for any mental illness in the past year. However, in recent years 2014-15 through 2016-17, RI adult depressive episode and serious mental illness

rates have moderately decreased, becoming comparable to the national rates. Having also decreased in RI, rates of any mental illness is still above the national average.

Efforts to include mental health promotion in the work of prevention coalitions 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 Workgroup
b) RI Substance Abuse Prevention Act (RISAPA)/Regional Prevention Task Force Grantees
c) Partnership 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.)

- Prevent and/or reduce consequences of underage drinking, ages 12-20 and adult problem drinking, ages 18-25.
- Prevent and/or reduce consequences of marijuana use by adolescents ages 12-20
- Prevent and/or reduce consequences of illicit drug use across the lifespan.
- Prevent or reduce consequences of 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. The Department and/or Contractor will try and enlist the Department of Motor Vehicles to assist with recruitment given the fact that youth turning 18 are required to obtain a new driver's license. Additionally, with the Real ID Act going into effect on October 1, 2020, many people statewide will be going to the DMV to obtain their new identification. If a partnership with the DMV is created, when people in the target age range go to the DMV to obtain their new license or Real ID, they will be given information about the survey at that time. This would allow for a broader reach of participants. 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
A. By 2019, reduce prevalence of alcohol use by 3% from 2016 baseline (NOM domain #1) • By 2019, increase the number of school districts implementing Project SUCCESS/ student assistance services from 27 to 30 B. By 2019, reduce prevalence of marijuana use by 3% from 2016 baseline (NOM domain #1) • By 2018, increase the number of in school youth expressing disapproval of use of ATOD by 10% over 2016 base line	i. Develop a funding stream to increase the number of schools implementing Project SUCCESS/student assistance services ii. Regional Prevention Coalitions will implement Mental health promotion activities iii. Identify a universal screening for use by Project SUCCESS	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)
C. By 2019, maintain/reduce tobacco sales violation rate at or below 20%. • By 2019, increase number of compliance checks (added enforcement) over 2018	i. Conduct compliance checks of retail outlets ii. Offer vendor training iii. Additional enforcement	% of tobacco retailers that sell tobacco to minors (Source: Synar Survey) # compliance checks # individuals trained
D. 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. Prescriber education/academic detailing ii. RX Take back days	# 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 2018 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.

Table of Contents

Introduction

Each year, about 120 Rhode Islanders die by suicide. Many people in Rhode Island have experienced suicide loss. And for many of us, understanding suicide or how we can prevent it can be difficult.

Suicide is a complex problem. Suicidal feelings and thoughts are not caused by just one thing, such as a mental health condition. A mental health condition can be a risk factor (something that increases the chance that a person may attempt suicide), but most people with a mental health condition will never attempt suicide. Many things can cause someone to attempt suicide, and each person's situation is unique.

There is not one simple or easy solution to prevent suicide. But it is possible to prevent suicide — to stop suicides before they happen. To do so, we need to reduce risks and increase protective factors (things that reduce the chance that a person may attempt suicide) for everyone in our State.

Everyone can help prevent suicide. Partnering across sectors to leverage expertise and implementing multiple strategies and approaches tailored to cultural needs and strengths can address the multiple factors associated with suicide. Commitment, cooperation, and leadership from public health, mental health, education, justice, healthcare, social services, business, labor, and government, among others, can drive significant improvements in suicide prevention.

The strategies in the Rhode Island Suicide Prevention Plan 2023-2030 focus on preventing the risk of suicide in the first place and lessening the immediate and long-term harms of suicidal behavior by helping those in times of crisis get the services and support they need. It was shaped by the voices of people on the front lines of our mental health and crisis systems and providers serving people at higher risk for suicide. Approximately 50 professionals with direct experience participated in interviews or focus groups that explored their ideas of how the state can improve its suicide prevention efforts. Their recommendations have been aligned with the *Centers for Disease Control and Prevention (CDC) Suicide Prevention Framework*, a group of overarching strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent suicide. We have contextualized these strategies with local experience to prioritize prevention activities.

The development of the Rhode Island 2023-2030 Suicide Prevention Strategic Plan was supported by the Substance Abuse and Mental Health Services Administration Community Mental Health Services COVID-19 Block Grant Supplemental funding. The grant was awarded to the Rhode Island Department of Behavioral Health, Developmental Disabilities, and Hospitals, and the work was completed through a memorandum of understanding with the Rhode Island Department of Health.

Thank you to all of the stakeholders that made time to talk with us and also all of the community partners who are doing valuable work to improve mental well-being and reduce suicides in Rhode Island.

Rhode Island Suicide Data

Rhode Island has one of the lowest rates of suicide deaths per 100,000 population in the country. The state is ranked 43rd of 50 in the nation in suicide deaths per 100,000 population and ranked second lowest in New England.[1] However, suicide is the 2nd leading cause of death for those aged 10-34 and the 11th leading cause of death among all Rhode Island residents (Table 1).[2]

Table 1: 10 Leading Causes of Death, Rhode Island, 2011-2020

Ranking	10-34 years	35-44 years	45-54 years	55-64 years
1	Accidents (unintentional injuries)	Accidents (unintentional injuries)	Cancerous tumors	Cancerous tumors
2	Intentional self-harm (Suicide)	Cancerous tumors	Accidents (unintentional injuries)	Heart diseases
3	Assault (Homicide)	Heart diseases	Heart diseases	Accidents (unintentional injuries)
4	Cancerous tumors	Intentional self-harm (Suicide)	Chronic liver disease and cirrhosis	Chronic lower respiratory diseases
5	Heart diseases	Chronic liver disease and cirrhosis	Intentional self-harm (Suicide)	Chronic liver disease and cirrhosis
6	Congenital malformations (diseases present at birth)	Assault (Homicide)	Diabetes	Diabetes
7	Chronic liver disease and cirrhosis	Cerebrovascular diseases (such as stroke and brain bleeding)	Cerebrovascular diseases (such as stroke and brain bleeding)	Cerebrovascular diseases (such as stroke and brain bleeding)
8	Diabetes	Diabetes	Chronic lower respiratory diseases	Intentional self-harm (Suicide)
9	Cerebrovascular diseases (such as stroke and brain bleeding)	Influenza and pneumonia	Septicemia	Septicemia
10	Influenza and pneumonia	Septicemia	Viral hepatitis	Influenza and pneumonia

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999-2020
Note: Some categories have been edited for plain language.

Deaths by Suicide

From 2011 through 2020, suicide accounted for the deaths of 1,107 residents[3] and cost the state over $169 million in lifetime medical and work loss costs, or $1.3 million per death by suicide.[4] During this period, the rate of deaths by suicide has remained relatively stable at 10.5 deaths per 100,000 population, rising slightly to 11.3 in 2019 and dropping to 8.7 in 2020 (18% fewer compared to the 2011-2020 average) during the pandemic. However, 2021 data shows that counts have returned to similar levels observed pre-pandemic.[5]

[1] Drapeau, C. W., & McIntosh, J. L. (2021). U.S.A. suicide: 2020 Official final data. Minneapolis, MN: Suicide Awareness Voices of Education (SAVE), dated December 24, 2021, downloaded from https://save.org/about-suicide/suicide-facts

[2] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999-2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999-2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html

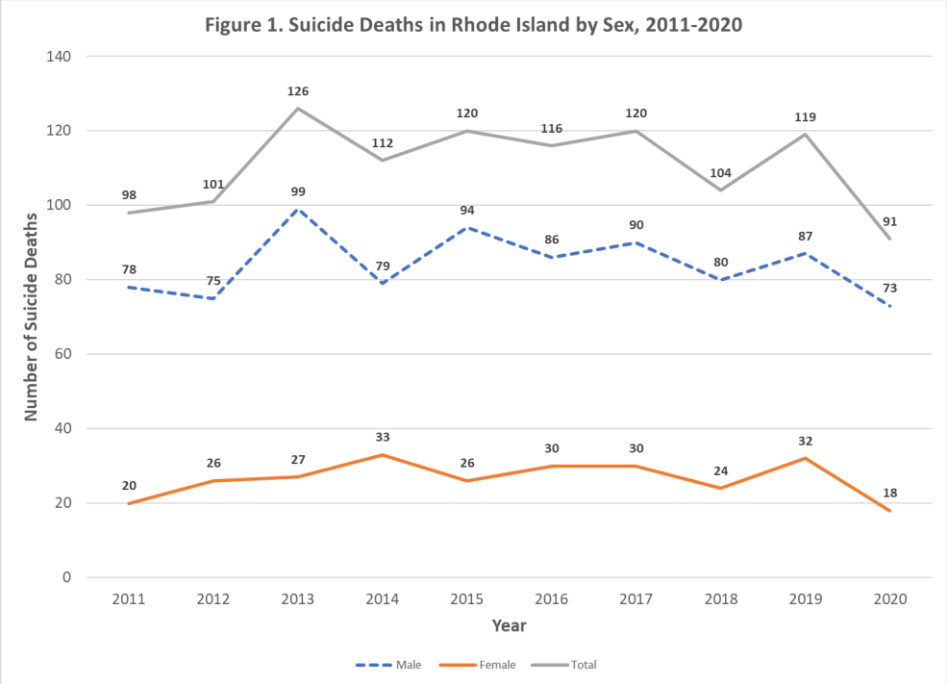
[3] Rhode Island Violent Death Reporting System (RIVDRS), 2011-2020, Suicide deaths that occurred in Rhode Island among Rhode Island residents

[4] American Foundation for Suicide Prevention, 2020

[5] 113 suicide deaths in Rhode Island among Rhode Island residents were reported during 2021. (Source: RIVDRS,).

Suicide rates vary by age, race/ethnicity, and other sociodemographic characteristics. Adults who died by suicide were more likely to be 35–64 years old, male, and non-Hispanic White:

- Overall, more males die by suicide than females in Rhode Island (Figure 1). The rate of suicide deaths among males in Rhode Island for 2011-2020 was about 3.38 times higher than for females. Males comprise more than 75% of suicide deaths and represent 50% of the population.
- Suicide deaths also disproportionally occur among middle-aged groups (ages 25-64), and less frequently among individuals older than 65 and youngerthan 25. Among people ages 25-64, the rate of suicide death is highest among people ages 45-54 (18.36 per 100,000) and 55-64 (16.39 per 100,000).
- Among people aged 65+ males are more likely to die by suicide than females,, while among people 45-54, females have a greater proportion of suicide deaths.
- White, non-Hispanic males represent 74% of the Rhode Island population older than ten years old and 88% of suicide deaths. In 2020, this same trend was observed; however, the percentage of deaths among White, non-Hispanic males was slightly lower at 82%.



Data Source: Rhode Island Violent Death Reporting System (RIVDRS), 2011-2020, Suicide deaths that occurred in Rhode Island among Rhode Island residents.

In addition, national data show that some other population groups disproportionately impacted by higher-than-average suicide rates include Veterans, workers in certain industries and occupations,[6] tribal populations, people who identify as LGBTQ+, people with prior incarcerations, and people experiencing certain risk factors, such as but not limited to:

- **Individual risk factors:** Previous suicide attempt, history of depression and/or other mental illnesses, serious illness such as chronic pain, criminal/legal problems, job/financial problems or loss, impulsive or aggressive tendencies, substance misuse, current or prior history of adverse childhood experiences, sense of hopelessness, violence victimization and/or perpetration.

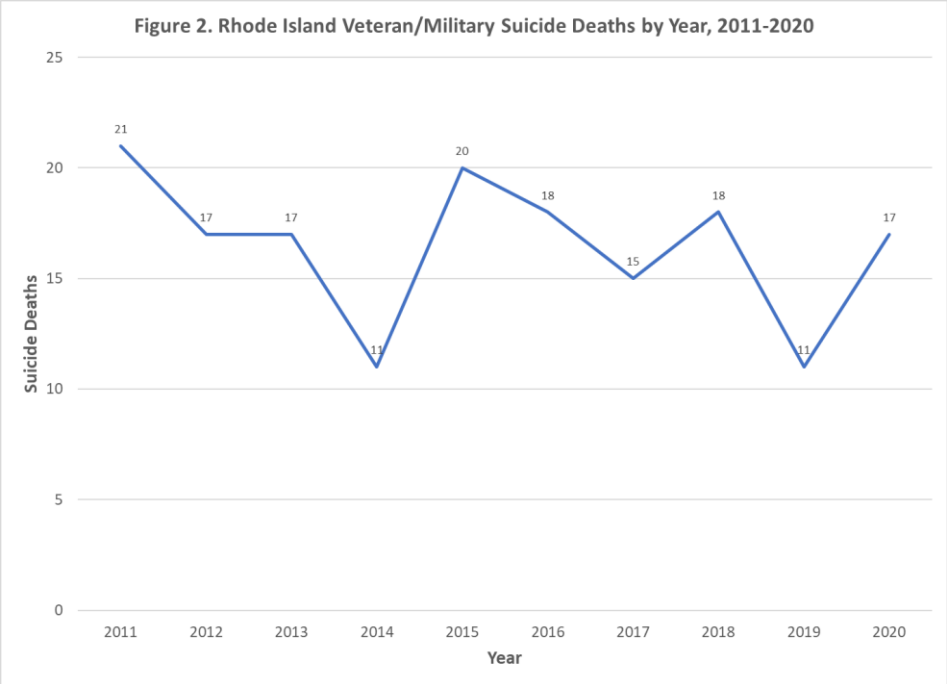
[6] For example, first responders, law enforcement, and construction workers.

- **Relationship risk factors:** Bullying, family/loved one's history of suicide, loss of relationships, high-conflict or violent relationships, social isolation.
- **Community risk factors:** Lack of access to healthcare, suicide cluster in the community, the stress of acculturation, community violence, historical trauma, discrimination.
- **Societal risk factors:** Stigma associated with help-seeking and mental illness, easy access to lethal means of suicide among people at risk, unsafe media portrayals of suicide.[7]

Transition periods are also associated with a higher risk of suicide. This includes transitions from work into retirement, from active-duty military to civilian status, from high school to college, and between levels of healthcare, such as from an inpatient psychiatric hospitalization to outpatient care. Due to the small number of deaths by suicide in Rhode Island, it is difficult to analyze and interpret mortality data for some of these groups and risk factors in a reliable way.

Veterans, Military Members,*[8] *and First Responders

From 2011 through 2020, 15 percent (165) of deaths by suicide were among Veteran/military members (approximately 11-21 deaths each year). Compared to the Rhode Island population who died by suicide, Veterans/miliary personnel who died by suicide were more likely to be male (98% compared to 76%), older (67% 55 years and older compared to 37%) and die by firearm (49% compared to 25%).For the same time period, suicide accounted for sixteen deaths (1%) among law enforcement and firefighters.



Data Source: Rhode Island Violent Death Reporting System (RIVDRS), 2011-2020, Suicide deaths that occurred in Rhode Island among Rhode Island residents.

Suburban Residents

[7] Centers for Disease Control and Prevention (CDC). (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[8] RIVDRS collects data on Veteran/Military status; however, it does not distinguish between whether the individual was active duty versus Veteran.

From 2011 through 2020, 55.5% (614) of deaths by suicide were among Providence County residents (Table 2). However, suburban regions (Bristol, Kent, Newport, and Washington County) had higher rates of deaths by suicide compared to other areas of the state:

Table 2: Rates of Suicide Death by County, 2011-2020 Combined

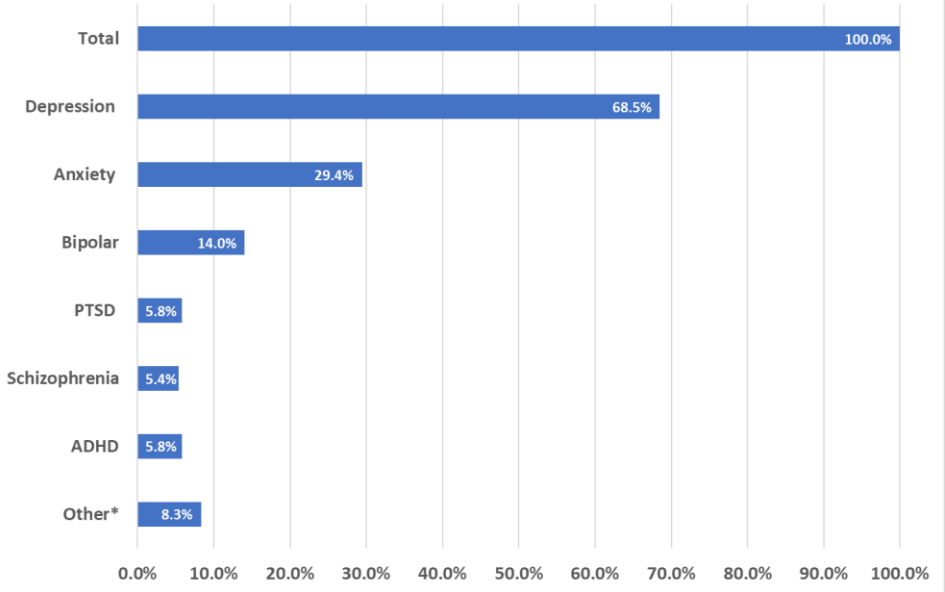
County	Rate per 100,000
Bristol County	12.2
Washington County	11.8
Kent County	11.4
Newport County	11.0
Providence County	9.8

Data Source: Rhode Island Violent Death Reporting System (RIVDRS), 2011-2020, Suicide deaths that occurred in Rhode Island among Rhode Island residents.

Precipitating Events and Risk Factors

Nearly 60% of adults who died by suicide had a current known mental health problem, and 51.4% were known to be receiving current treatment.[9] Of those with known mental health problems, 435 were diagnosed with depression (68.5%), 187 were diagnosed with anxiety (29.4%), 89 were diagnosed with bipolar disorder (14.0%), 5.8% were diagnosed with post-traumatic stress disorder (PTSD), 5.8% were diagnosed with attention-deficit/hyperactivity disorder (ADHD), and 5.4% were diagnosed with schizophrenia. Twenty-two percent (239) had a known alcohol problem, and 175 had another (non-alcohol) substance use disorder (22.4%). One percent (12) had a known addiction other than alcohol or another substance misuse.

Figure 3. Mental Health Diagnoses Among 635 Rhode Island Suicide Deaths with a Known Mental Health Problem, 2011-2020



Data Source: Rhode Island Violent Death Reporting System (RIVDRS), 2011-2020, Suicide deaths that occurred in Rhode Island among Rhode Island residents.

[9] 1,066 of the 1,107 suicide deaths during this time had circumstance information available (96.3%). Percentages were calculated among deaths with known circumstances in RIVDRS.

The most common precipitating events were a current known behavioral health problem, a past suicide attempt, a known intimate partner problem, a crisis reported within two weeks before death, a medical problem, a family relationship problem, a job problem, a recent criminal legal problem, and a financial problem, including known recent eviction or loss of income.

In addition, access to lethal means is associated with increased suicide risk.[10] Firearms are Rhode Island's second most common injury mechanism, followed by poisoning. In addition, mortality data show that 48 suicide deaths were bridge-related between 2011-2020. Most of these deaths occurred in Newport County (n=27), followed by Bristol County (n=10).[11]

Suicide Attempts

Suicide deaths reflect only a portion of the problem. In Rhode Island, the percentage of adults reporting serious thoughts of suicide is 4.59 (38,000 people). The number of adults in Rhode Island experiencing suicidal ideation has slightly increased each year since 2015.[12] This increase is not reflected in hospital admissions related to suicide attempts/intentional self-harm, which remained relatively constant from 2017-2021 with one exception: 10-34-year-old females. Specifically for females, the rate of visits related to suicide attempts/intentional self-harm increased by 32%, from 7.8 per 1,000 in 2017 to 10.3 per 1,000 in 2021 (a statistically significant increase). Overall, during this period, a total of 7,817 emergency department (ED) visits and 4,888 hospital admissions related to intentional self-harm/suicide attempts were identified.[13] While most suicide deaths are among middle-aged men, 60% of ED visits and hospitalizations relating to intentional self-harm/suicide attempts are among females, and are more likely to occur among younger age groups (10-34). Also, while most deaths and ED visits/hospitalizations occur among White, non-Hispanic individuals, Hispanic and Black individuals and individuals with a race/ethnicity recorded as "other, non-Hispanic" had higher rates of hospital admissions.[14] Among counties, Bristol County had the highest rates of emergency department visits related to intentional self-harm from 2017-2021.

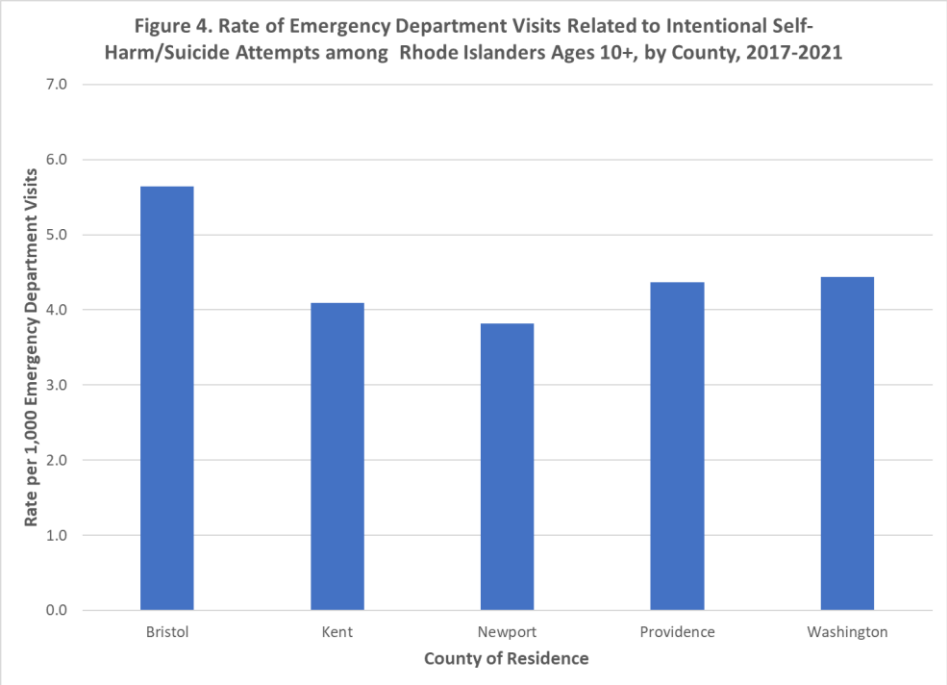
[10] https://www.hsph.harvard.edu/means-matter/means-matter/risk/

[11] Bridge-related suicides that occurred in Rhode Island, 2011-2020, RIVDRS

[12] https://mhanational.org/issues/2022/mental-health-america-adult-data

[13] Data includes emergency department visits and hospitalizations among Rhode Island residents ages 10 years and older. Includes all acute care hospitals in Rhode Island; excludes specialty hospitals/rehabilitation centers. Visits and hospitalizations relating to intentional self-harm/suicide attempts were identified based on the presence of ICD-10 codes in any diagnosis field. Totals for emergency department visits include visits where the patient was subsequently admitted to the hospital.

[14] A note about "other, non-Hispanic": Rhode Island is not able to evaluate suicide rates for the many different ethnic groups contained within this category due to the Department of Health's small numbers policy. Among other groups, this category contains Asian and Pacific Islander people, and American Indian/Alaskan Native people. In particular, it is important to recognize that national evidence tells us that American Indian/Alaskan Native people are more likely than any other racial or ethnic group to die by suicide.



Data Source: Rhode Island Hospital Discharge Data, RIDOH, 2017-2021.
Notes: Data includes emergency department visits and hospitalizations among Rhode Island residents ages 10 years and older. Includes all acute care hospitals in Rhode Island; excludes specialty hospitals/rehabilitation centers. Visits and hospitalizations relating to intentional self-harm/suicide attempts were identified based on the presence of ICD-10 codes in any diagnosis field. Totals for emergency department visits include visits where the patient was subsequently admitted to the hospital.

The number of youth experiencing suicidal ideation has also increased. Data from the 2021 Rhode Island Youth Risk Behavior Survey (YRBS) show that there has been a significant increase in serious thoughts about suicide and suicidal attempts among young Rhode Islanders since 2011. For example, during that period:

- The percentage of high school students seriously considering attempting suicide increased from 12.3% to 17.1%.
- The percentage of high school students whomade plans to attempt suicide increased from 10.7% to 14.5%.

This was exacerbated during the COVID-19 pandemic when ED visits for suspected suicide attempts began to increase among teens ages 12 to 17. By February-March 2021, ED visits for suspected suicide attempts were 50.6% higher among females age 12-17 than during the same period in 2019. Among males in this age group, suspected suicide attempt ED visits increased by 3.7%.[15]

[15] Emergency department (ED) visit data from the National Syndromic Surveillance System, Centers for Disease Control and Prevention (CDC)

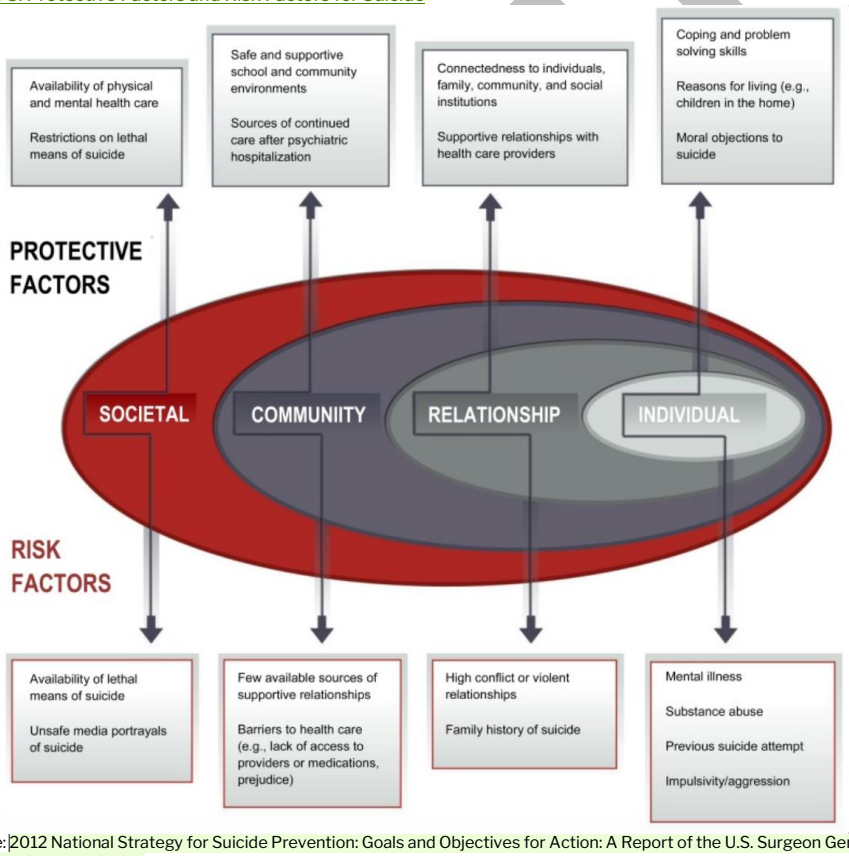
Research-Validated Suicide Factors

Many things can contribute to someone's risk of suicide. It can occur in response to a complex interplay between individual, relationship, community, and societal risk factors. These include Adverse Childhood Experiences (ACEs), substance use, poverty, untreated mental illness, and unmet basic needs. The presence of risk factors does not predict suicide or suicide attempts for any given person. Most individuals who experience risk factors or attempt suicide do not die by suicide. However, the cumulative effect of several risk factors may increase an individual's vulnerability to suicidal behaviors.

It is also important to remember that risk factors can vary by age group, culture, sex, and other characteristics.[16] For example:

- Stress resulting from prejudice and discrimination (family rejection, bullying, violence) is a known risk factor for suicide attempts among lesbian, gay, bisexual, and transgender (LGBT) youth.
- The historical trauma suffered by American Indians and Alaska Natives (resettlement, destruction of cultures and economies) contributes to the high suicide rate in this population.
- For men in their middle years, stressors that challenge traditional male roles, such as unemployment and divorce, have been identified as important risk factors.

Figure 5: Protective Factors and Risk Factors for Suicide



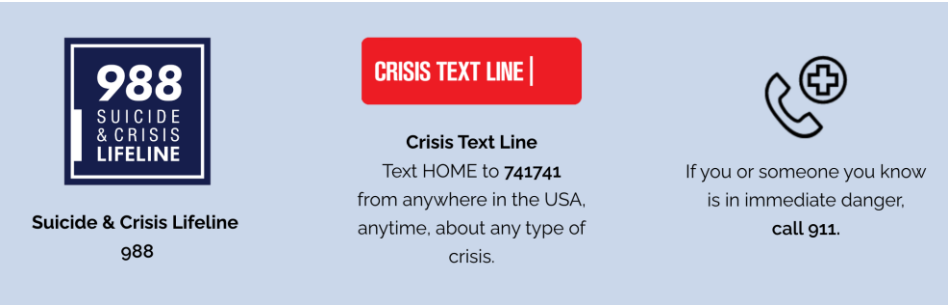
Source: 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action

[16] Centers for Disease Control and Prevention (CDC). (2022). *Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence*. Atlanta, GA: National Center for Injury Prevention and Control, CDC.

Commented [1]: Design notes: If we recreate this figure, let's make "health care" one word to align with RIDOH style standards. Also, there is a typo in the middle of the figure, in the word "Community".

Commented [2]: We also need to change substance abuse to substance use disorder.

Commented [3]: thank you - good catch!



Alliance for Suicide Prevention.

Protective factors can either counter a specific risk factor or buffer against multiple risks associated with suicide. Belonging, safety, dignity, and hope can support resilience and healing for individuals and communities and protect against suicide.

The visual above shows the risk and protective factors that must be considered.

HELP IS AVAILABLE

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Strategic Plan Core Assumptions, Guiding Framework, and Process

Rhode Island's Suicide Prevention Plan is comprehensive and data driven. The strategies in the Suicide Prevention Plan for Rhode Island focus on preventing the risk of suicide in the first place and lessening the immediate and long-term harms of suicidal behavior by helping those in times of crisis get the services and support they need.

It was shaped by the voices of practitioners in the field and providers serving people at higher risk for suicide, who are valuable resources for assessing needs and strengths and making recommendations. Approximately 50 professionals with direct experience participated in interviews or focus groups that explored their ideas of how the state can improve its suicide prevention efforts.

Their recommendations have been aligned with the *CDC Suicide Prevention Framework*, a group of overarching strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent suicide. We have contextualized these strategies with local experience to prioritize prevention activities.

The *CDC Suicide Prevention Framework* is based on the following core assumptions:

- Suicide is a public health issue.
- Any single factor does not cause suicide, and any single strategy or approach will not achieve suicide prevention.
- Suicide occurs in response to multiple biological, psychological, interpersonal, environmental, and societal influences that interact, often over time.
- Belonging, safety, dignity, and hope can support resilience and healing for individuals and communities and protect against suicide.
- Suicide, adverse childhood experiences (ACEs), and substance use are connected. ACEs refer to three specific kinds of adversity children can face in the home environment—various forms of physical and emotional abuse, neglect, and household dysfunction.
- Suicide can contribute to lasting impacts on individuals, families, and communities.

It focuses on the following priorities and goals[17] to achieve and sustains substantial reductions in suicide.

Priority	Goals
Strengthen Economic Supports	• Improve household financial security • Stabilize housing
Create Protective Environments	• Reduce access to lethal means among persons at risk of suicide • Reduce substance use through community-based policies and practices
Improve Access to Delivery of Suicide Care	• Cover mental health conditions in health insurance policies • Increase provider availability • Provide rapid and remote access to help • Create safer suicide care through systems change
Promote Healthy Connections	• Promote healthy peer norms • Engage community members in shared activities
Teach Coping Skills and Problem-Solving Skills	• Support social-emotional learning programs • Teach parenting skills to improve family relationships • Support resilience through education programs
Identify and Support People at Risk	• Train gatekeepers • Respond to crises • Plan for safety and follow-up after an attempt

[17] Centers for Disease Control and Prevention (CDC). (2022). *Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence*. Atlanta, GA: National Center for Injury Prevention and Control, CDC.

Priority	Goals
	• Provide therapeutic services
Lessen Harms and Prevent Future Risk	• Intervene after a suicide (postvention) • Report and message about suicide safely

Rhode Island's Suicide Prevention Plan 2023-2030

Our goal is to reduce suicide mortality by 10% by 2026 and 15% by 2030.

Priority 1: Strengthen economic supports

Historical trends in the US indicate that suicide rates increase during economic recessions marked by high unemployment rates, job losses, and economic instability and decrease during economic expansions and periods marked by low unemployment rates, particularly for working-age individuals 25–64 years old. Economic and financial strain may increase an individual's risk for suicide or indirectly increase risk by exacerbating existing physical and/or mental illnesses. Financial strains could include job loss, long periods of unemployment, poverty, reduced income, difficulty covering medical, food, and housing expenses, and even the anticipation of such financial stress. Eviction and homelessness are also related to suicide. Reducing these stressors can potentially buffer suicide risk.[18]

Goal 1: Strengthen household financial security

According to the 2022 Rhode Island Standard of Need Report (RISN),[19] many Rhode Island households do not earn enough to make ends meet, a circumstance more commonly experienced by Latino and Black households than White households. Across racial and ethnic groups, women without children are much less likely to be able to make ends meet than men without children. Overall, Rhode Island households earning less than what is necessary to meet the RISN include:

- 61% of single adults without children.
- 70% of families with one caregiver and two children.
- 25% of families with two caregivers and two children.

Work support programs can help narrow the gap between earnings and expenses. Since Black and Latino Rhode Islanders are overrepresented as a share of Rhode Island's low-wage workers, enhancing such programs and paying all workers a living wage would decrease disparities and increase economic security and opportunity. Also, families receiving and relying upon Rhode Island Works cash assistance (including the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)) have incomes on average 26% below the Federal Poverty Level. Without subsidies from the Child Care Assistance Program (CCAP) and through HealthSource RI (Rhode Island's official marketplace for health insurance coverage), working families — including frontline and essential workers — have a large gap between income and expenses for basic needs.[2]

Strategies

- Support efforts to increase the Rhode Island minimum wage to a fair living wage, narrow the gap between earnings and basic expenses, and expand and strengthen cash assistance and tax credits.
- Expand eligibility and benefits for CCAP.
- Expand eligibility and benefits for SNAP and cash benefits.
- Ensure automatic enrollment in public benefits when someone enters the shelter system.
- Support efforts to limit loan interest rates (APR) to 36% and establish guardrails around loan structure to protect consumers.
- Promote screening for basic needs and referrals to community-based services via UniteUs, Rhode Island's Community Resource and Referral platform.
- Enact equitable utility regulations/policies that limit the proportion of income required to maintain basic electric service, ensure equitable access to on-site energy generation, storage, and energy efficiency technologies—and the savings and resilience benefits they can provide—and ensure uninterrupted and affordable access to a basic level of electricity service.
- Make changes to medical debt laws so that residents with medical debt cannot be pursued by debt collectors or sent to court.

[18] Centers for Disease Control and Prevention (CDC). (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, CDC

[19] https://www.economicprogressri.org/rhode-island-standard-of-need-8/

- Support community-driven efforts to destigmatize and provide for basic needs in naturally occurring settings such as churches, libraries, community centers, and schools.

Goal 2: Continue to invest in housing stabilization

Housing affordability is a statewide challenge across all income, racial, and age groups, but especially for low- and moderate-income households, underscoring the need to build more affordable housing and provide rental assistance. More than 139,000 Rhode Island households, or nearly 34%, are cost burdened, paying more than 30% of their income toward housing.[2] Rent has increased by 24% in the past year. Low- and moderate-income families, including older adults on a fixed income, struggle to find affordable housing and prevent eviction.[2] It is also important to note that access to housing in Rhode Island is not an equal playing field. Black Rhode Islanders and other people of color face greater housing unaffordability and insecurity. Historical race and class discrimination have produced deep-rooted gaps in generational wealth and patterns of segregated neighborhoods, and a continued lack of access to credit and affordable housing.[20] For Rhode Islanders experiencing homelessness, there is an approximately 30-day wait for a shelter bed in Rhode Island.[21] Those who shelter in tents or cars are vulnerable to violence; their tents are frequently slashed or encampments bulldozed. As a result, they lose their shelter, personal items like pictures, and often important documents that enable them to enroll in benefits and work.

Rhode Island has several programs and initiatives that address housing challenges in the state, including eviction assistance, affordable housing support, permanent supportive housing, and more. This includes deploying more than $11.6 million in rental assistance through Safe Harbor and Housing Help RI and more than $53 million through Rent Relief RI to thousands of Rhode Island families throughout the pandemic. However, key informants noted there is still a three- to ten-year wait[22] for subsidies, depending on the funding source, exposing many to homelessness, overcrowding, eviction, and other hardships while they wait. In addition, the State of Rhode Island does not have a State-funded rental assistance program available to residents to reduce the unmet need for assistance.

The State has also implemented a five-year Pay for Success permanent supportive housing pilot. It has increased funding to eliminate health hazards (lead, asbestos, etc.) and improve housing stock. It has also allocated American Rescue Prevention Act (ARPA) funds to expand housing stabilization and diversion services.[23] However, ARPA funding is temporary, and implemented initiatives must be sustained.

The State and Rhode Island Housing are also investing more than $250 million to create and preserve more affordable homes across the state through a combination of State and federal resources. However, the expansion of affordable housing depends partly on the provisions laid out in the local zoning ordinance or code. For example, some zoning policies specify that there may be only one dwelling unit per parcel of land (restricting the development of accessory dwelling units) or prohibit the use of manufactured housing in particular residential districts. To expand affordable housing units within communities, many local jurisdictions need to revise their zoning policies to allow the market to develop these units in some or all parts of town.

In addition, more can be done to control rent increases, prohibit discrimination based on arrest or conviction records, support people taken to Eviction Court, sustain housing stabilization services, and protect people experiencing homelessness.

Strategies

- Increase affordable and supportive housing funding to proportionately equal or exceed Rhode Island's neighboring states.
- Expand the total number of public and supportive housing units available in Rhode Island.
- Expand federal rental subsidies and create a State rental subsidy program.

[20] ttps://www.providencejournal.com/story/news/local/2022/06/16/brown-university-report-ri-racial-gap-owning-house/7633908001/

[21] The wait time for a shelter changes daily. At the time of the interview, the RI Coalition for the Homeless reported a 30-day wait.

[22] https://www.cbpp.org/research/housing/families-wait-years-for-housing-vouchers-due-to-inadequate-funding

[23] Diversion is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing.

- Work with cities and towns to create a more favorable planning, zoning, and development environment (e.g., facilitate community-level partnerships to identify buildings or properties that can be turned into affordable or supportive housing).
- Support efforts to establish rent control and eliminate rental application fees so landlords cannot increase rent by more than 10% within a ten-month period. Include private landlords, public housing managers, and tenants in decision-making.
- Expand funding for housing stabilization and diversion services.
- Increase the number of providers of home stabilization services (e.g., support public housing authorities to become certified providers of home stabilization services).
- Support efforts to increase staffing capacity to deliver housing stabilization services. For example, amend certification standards to remove requirements for an associate or bachelor's degree and one year of experience. (Note: a request for this is pending with the Centers for Medicare & Medicaid Services).
- Support efforts to provide free legal counsel to people taken to Eviction Court.
- Support efforts to establish Fair Chance Housing to prohibit discrimination based on arrest or conviction record.
- Enforce the homeless bill of rights.
- Support efforts to allow emergency shelters to be opened anywhere they are needed.

Priority 2: Create protective environments

A person's environment can significantly influence the accessibility of lethal suicide means. Creating environments that reduce risk factors and increase protective factors where individuals live, work, and play can help prevent suicide. In particular, modifying physical environment characteristics, such as access to lethal means among people at risk, can prevent harmful behavior and reduce suicide rates, particularly in times of crisis or transition.[24]

Goal 1: Reduce access to lethal means among persons at risk of suicide

Means of suicide, such as firearms, hanging or suffocation, or jumping from heights, provide little opportunity for rescue. These means result in high case-fatality rates. Almost 90% of people who use a firearm in a suicide attempt die from their injury. Research also indicates that the interval between deciding to act and attempting suicide can be as short as 5 to 10 minutes. People tend not to substitute a different method when a highly lethal method is unavailable or difficult to access. Reducing access to lethal means among people at risk and increasing the time interval between deciding to act and the suicide attempt can be lifesaving.[6]

Safe Storage
Safe storage of medications, firearms, and other harmful household products can reduce the risk of suicide by separating individuals at elevated risk of suicide from easy access to lethal means. Such practices may include storing firearms in a gun safe or lock box, unloading and separating ammunition from the firearm, and keeping medicines and hazardous household products in a locked box or another secure location. Providing a safe storage device may also be combined with education and counseling about access to lethal means to enhance adherence to safe storage practices. Approaches that effectively limit access to firearms within the home by enhancing safe storage practices help prevent adult and youth suicide alike.[25]

Firearms
In Rhode Island, firearms are the second most common injury mechanism across all deaths by suicide, followed by poisoning.[3] There are two laws stipulating the safe storage of firearms: (1) R.I. Gen. Laws § 11-47-60.3 provides that any retail sale of a pistol must include a trigger lock or other safety device designed to prevent an unauthorized user from operating the pistol, and (2) R.I. Gen. Laws § 11-47-60.1 imposes criminal liability on any person who leaves a loaded firearm on their premises and who reasonably should know that a child could obtain access to the firearm, if an injury results. In contrast, Massachusetts law requires that all guns be stored in a locked container or be equipped with a locking device whenever not in active use and provides for higher penalties if the firearm involved is an assault weapon or if a minor can access the weapon. It also provides that violation of the law may be used as evidence of reckless conduct in a criminal or civil legal proceeding. There is early evidence that this clear law helps to incentivize extra precaution when safely

[24] Centers for Disease Control and Prevention (CDC). (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, CDC.

[25] Centers for Disease Control and Prevention (CDC). (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, CDC.

storing guns and may help reduce the risk of youth suicide: Guns are used in just 9% of youth suicides in Massachusetts, compared to 39% of youth suicides nationally, and the overall suicide death rate among youth in Massachusetts is 35% below the national average.

Safe Storage of Medication
The regional Rhode Island Prevention Coalitions provide medication lock bags to anyone who requests one free of charge. In addition, there are 39 permanent prescription drug disposal sites at pharmacies, health centers, police departments, and methadone clinics throughout the state, where anyone can anonymously drop off prescription drugs without questions. The state also holds two "Drug Take Back" events each year.

Bridge Access
Efforts to prevent suicide at bridge locations, such as erecting barriers and installing signs and telephones to encourage individuals who are considering suicide to seek help, can also help to prevent death by suicide.[2]

Rhode Island consists of four major islands connected by several large overwater bridges. Three of these bridges (Mount Hope Bridge, the Newport Pell Bridge, and the Jamestown Verrazano Bridge) have been used more than others to end one's life. All three bridges are owned and operated by the Rhode Island Turnpike and Bridge Authority (RITBA), a quasi-public agency whose operating revenues come primarily from tolls paid by motorists crossing the Pell Bridge.[26] Mortality data show that 48 suicide deaths were bridge-related between 2011-2020. Most of these deaths occurred in Newport County (27), followed by Bristol County (10).[27]

Some interventions are already in place to reduce suicides using these bridges. For example, signs are posted near the bridge entrances on both the Jamestown and Mount Hope bridges, installed in 2013 and 2019, respectively. These signs provide the numbers for emergency services (911) and the Samaritans of Rhode Island. Additionally, there are traffic cameras installed on some of the bridges, which could be used to detect potential suicidal activity. However, these cameras are owned and operated by several different non-emergency response organizations (e.g., RITBA, Rhode Island Department of Transportation (RIDOT), and Rhode Island Emergency Management Agency (RIEMA)). Live camera access must be requested by rescue responders, restricting the timeliness of the information the videos could provide. While the RIDOT cameras are viewable, live, and directly accessible to 911, these cameras are fixed on the approaches to the bridges (not on the span where suicides are more likely to occur) and do not offer first responders the ability to zoom in to see events as they unfold.[28]

In addition, new interactive pan-tilt-zoom (PTZ) cameras[29] and communications systems have been installed on the Newport Pell and Mount Hope Bridges. While not yet fully operational, the new surveillance systems will alert a RITBA staff member if an unauthorized person or car is stopped on the bridge. If the staff member believes the person intends to harm themselves, they will notify the authorities and trigger an automated, pre-recorded message over loudspeakers, saying, "You are not alone; trained professional help is on the way." The system also has sophisticated audio and video analytic capabilities for pinpointing rescue locations in the water without delay. According to RITBA, these cameras will be monitored 24/7 by a RITBA staff member.[4]

However, cameras are not enough. While there is limited data, one study that examined camera effectiveness found that cameras and signs worked best in conjunction with other means, including operator monitoring/engagement and means restriction via bridge suicide barriers.[30] Research on structural bridge barriers has demonstrated strong evidence that physical barriers significantly decreased suicide rates on the bridges where they were installed.[4] Based on this evidence, local advocacy groups and the Bristol Health Equity Zone have introduced legislation for the past four legislative sessions that, if passed, would direct RIDOT, in conjunction with the RITBA, to erect the barriers on the Mount Hope Bridge, the NewportPell Bridge, and the Jamestown Verrazzano Bridge. While these bills did not pass in 2022, the legislature appropriated $1 million in ARPA funding in the State Fiscal 2023 budget to support a design study for some

[26] Cottle, J.L., Fuller, M., & Avila, S. (May 2021). Suicide Barriers on RI Bridges.

[27] Rhode Island Violent Death Reporting System (RIVDRS), 2011-2020, Suicide deaths that occurred in Rhode Island among Rhode Island residents.

[28] Cottle, J.L., Fuller, M., & Avila, S. (May 2021). Suicide Barriers on RI Bridges.

[29] PTZ cameras are built with mechanical parts that allow them to swivel left to right, tilt up and down, and zoom in and out of a scene.

[30] Bennewith O, Nowers M, Gunnell D. (2011). Suicidal behaviour and suicide from the Clifton Suspension Bridge, Bristol and surrounding area in the UK: 1994-2003. European Journal of Public Health, 21 204-8.. doi: 10.1093/eurpub/ckq092.

of the bridges. (Note: the cost to study all four bridges is $1.5 million.) The studies for the Jamestown Verrazano and Mount Hope bridges began January 2023.

Strategies

- Distribute medication lock bags, timer caps, and gun locks through partnerships with emergency departments, prevention coalitions, and the Rhode Island Office of Veteran Services.
- Include medication lock boxes as a value-add service in Medicaid managed care contracts.
- Utilize national and local technical assistance to bring safe firearm storage sites to Rhode Island.
- Continue to promote safe medication disposal at pharmacies, health centers, police departments, and methadone clinics.
- Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership. Encourage firearm dealers and firearm ranges to display 988 information and suicide prevention resources.
- Support efforts to amend Rhode Island's current safe storage law to more closely mirror Massachusetts' safe storage law, which requires that all firearms be stored in a locked container or with an approved locking device when not in use. Implement graduated criminal penalties for violations of the law.
- Support efforts to expand the current law to require approved locking devices to be provided with every gun sale, not just handgun sales at federally licensed firearms dealers. Such legislation could be modeled on laws in California, New York, and Michigan, which all have more expansive laws regarding the sale of locking devices.
- Encourage all gun dealers to display and make available information regarding the safe storage of firearms. Include this information in a revamped safety course and test required to obtain a Blue Card.[31]
- Implement strategies to reduce lethal means access in high-risk locations: bridges, train stations/tracks, public parking garages, and public parks. For example:
    - Support efforts to require restrictions barriers to be integrated into future bridge repair and reconstruction plans.
    - Support efforts to erect the barriers on the Mount Hope Bridge, the Newport Pell Bridge, and the Jamestown Verrazzano Bridge.

Goal 2: Reduce substance use through community-based policies and practices

There is a strong relationship between substance use disorders and suicide-related outcomes, including suicidal ideation, attempts, and deaths. Research studies in the US have found that greater alcohol availability is positively associated with alcohol-involved suicides. A literature review found that acute alcohol use was associated with more than one-third of suicides and approximately 40% of suicide attempts. Studies have also revealed a connection between suicide attempts and other substance misuse, such as opioids. One analysis revealed a dose-response relationship between suicide and opioids prescribed for pain, depicting higher suicide rates among those with higher-dose prescriptions.[32]

Rhode Island has seven Regional Prevention Task Forces responsible for overseeing the planning and delivery of substance-use prevention activities within the region's municipalities. Each Task Force includes city and town representation, which ensures that individual communities continue to play an active role in planning and service delivery. The regional Task Forces provide administrative oversight, funding, and other needed resources to support the smaller municipal coalition contributions as part of the larger regional prevention plan.

The Regional Prevention Task Forces work to prevent substance use among children, including information dissemination, peer education, alternative events, evidence-based education curriculums, and environmental strategies, including changing local laws and policies and high-visibility youth access law enforcement efforts. Figure 6 shows examples of some of the programs and campaigns the coalitions have provided to the community. Items in bold are evidence-based practices. Items with an asterisk are locally developed or national strategies that do not meet criteria for an evidence-based practice.

[31] Possession of a Pistol/Revolver Safety Certificate, also known as the "blue card," is a required document as part of the process to purchase a handgun and/or ammunition in Rhode Island. The blue card certifies that the applicant has successfully passed the State's requisite safety exam.

[32] Centers for Disease Control and Prevention (CDC). (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, CDC.

Figure 6: Rhode Island Regional Prevention Task Force Programs and Campaigns

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Notes: Items in bold are evidence-based practices. Items with an asterisk are locally developed or national strategies that do not meet criteria for an evidence-based practice.

Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) is a multi-component, evidence-based intervention that has been shown to prevent and reduce substance use and promote mental wellness among youth ages 12-18. The project includes a universal prevention education curriculum as well as the utilization of student assistance counselors to provide problem identification and referral services. It is the primary problem identification and referral strategy utilized by the State and is implemented by the Rhode Island Student Assistance Services (RISAS), which provides evidence-based programs in schools and communities to prevent substance use and promote mental health. By the beginning of the September 2023 school year, Project SUCCESS will be in 82 middle and high schools throughout Rhode Island.

Project SUCCESS utilizes a multi-pronged strategy:

- ***Prevention Education Series (PES)***: The PES is a 4- topic alcohol, tobacco, and drug classroom-based program that targets 7th and 9th graders. It aims to help students identify and resist pressures to use substances, correct misperceptions about the prevalence and acceptability of substance use, and understand the consequences of substance use. In addition to teaching information designed to increase the perception of harm and improve coping strategies, PES aims to generate self, peer, and faculty referrals to the school's student assistance counselor (SAC). When students see the counselor present in the classroom, it encourages help-seeking behavior in a non-stigmatizing setting.
- ***Assessment and Brief Intervention:*** SACs utilize the Project SUCCESS assessment protocol described in the Program Manual, which includes a comprehensive assessment of current

psychological functioning and the CRAFFT Screening Questions[33]. SACs conduct time-limited individual and group sessions utilizing motivational interviewing strategies. The sessions are designed to prevent and reduce substance use and other high-risk behaviors. All SACs have been trained in Screening, Brief Intervention, and Referral toTreatment (SBIRT), Motivational Interviewing, and Brief Challenges approaches.

- ***Universal Prevention:*** SACs conduct monthly school-wide activities to coincide with the calendar of awareness weeks/months in the Project SUCCESS calendar. These activities influence attitudes and norms about substance use and related high-risk behaviors in school and the community. They are sometimes done in collaboration with the Rhode Island Regional Prevention Task Forces.
- ***Parent Program/Outreach:*** SACs implement parent outreach and education based on the school's individual needs, often in coordination with the Rhode Island Regional Prevention Task Forces. These are designed to provide information concerning Project SUCCESS and its services, as well as current substance use trends within the school or community. They also provide resources to parents to increase their knowledge or that of their child regarding the consequences of substance use, risk, and protective factors for substance use.

Strategies

- Continue to invest in efforts to increase awareness and prevent substance use by youth, such as Project SUCCESS.
- Support and reinforce the comprehensive community prevention strategies being implemented by the Regional Prevention Task Forces.

Priority 3: Improve access to and delivery of care

Most people with mental health conditions never attempt or die by suicide, but these disorders are important risk factors for suicide. According to Mental Health America,[34] less than half (49%) of adults in Rhode Island with mental health disorders receive treatment for these conditions. Lack of access to mental healthcare contributes to underusing mental health services. This may be particularly pertinent for people with serious mental illness, people from racial and ethnic minority groups, underserved communities, rural communities, and uninsured people. Poverty, combined with factors such as social stigma, mistrust of the behavioral health system, and lack of cultural adaptation of interventions, is associated with underusing mental health services. Identifying ways to improve access to timely, affordable, culturally appropriate, and quality care for people at risk for suicide is critical to prevention.[35]

Goal 1: Cover mental health conditions in health insurance policies

In 2008, Congress passed the Mental Health Parity and Addiction Equity Act, which requires that insurers cover mental health, including addiction treatment, no more restrictively than medical and surgical treatment. However, our key informants and a report issued by the Mental Health Association of Rhode Island (MHARI) in 2020[36] reveal that insurers in Rhode Island continue to restrict access to mental health and substance use disorder treatment services and have insufficient networks of mental health providers covered by health insurance plans. In addition, key informants report that Medicaid-eligible patients in Rhode Island have greater access to mental and behavioral health services than those covered by private insurance. However, the Medicaid provider reimbursement rates are significantly lower than commercial reimbursement rates. As a result, the salary levels in agencies that predominantly serve Medicaid-eligible patients with complex needs are so low that they must rely heavily on inexperienced, unlicensed clinicians to provide services. Once those clinicians complete the hours required for licensing, they typically leave for other settings, where they are paid 80-100% more. This results in high clinician turnover, limiting access to quality care and contributing to poor health outcomes for Medicaid beneficiaries, who are disproportionately people of color.

Strategies

[33] The CRAFFT is a health screening tool designed to identify substance use, substance-related riding/driving risk, and substance use disorder among youth ages 12-21. https://crafft.org/about-the-crafft/

[34] https://mhanational.org/issues/2022/ranking-states

[35] Centers for Disease Control and Prevention (CDC). (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, CDC.

[36] https://mhari.org/wp-content/uploads/2020/07/ParityReport2020Final.pdf

- Ensure that mental health and addiction treatment is covered at the same level as care for other health conditions.
- Prioritize reimbursement rate increases for behavioral health services to help incentivize the availability of needed behavioral health services. (See Goal 2 below.)
- Increase enforcement of parity of behavioral health coverage and reimbursement rates between private and public insurance.

Goal 2: Increase provider availability

Access to effective and state-of-the-art mental healthcare largely depends upon quality training and an adequate mental healthcare workforce. In Rhode Island, there are several areas where access to quality mental healthcare needs is limited due to an inadequate number of providers. Specifically, Rhode Island needs:

More community-based licensed mental and behavioral health clinicians[37] with expertise serving populations at higher risk of suicide: There are long wait times for outpatient services, with many providers not participating in the insurance system due to low reimbursement rates and lack of parity between rates for behavioral health services and those for medical services. In addition, there are a very limited number of clinicians with important expertise or lived experience, including but not limited to:

- Clinicians trained to provide care to survivors of intimate partner violence.
- Clinicians trained in geriatric behavioral healthcare.
- Clinicians trained to provide gender- or LGBTQ-affirming care and/or with related lived experience.
- Clinicians equipped to provide trauma-informed services.
- Clinicians trained to provide suicide prevention-focused psychotherapy, such as Cognitive Behavioral Therapy (CBT), Collaborative Assessment and Management of Suicidality (CAMS), Safety Planning (using the Stanley Brown instrument), and Dialectical Behavior Therapy (DBT). (See Priority 6, Goal 4 for more detail.)

Interviewees also report difficulties in finding therapists who are Black, Indigenous, or people of color and note that many clinicians will not work with adults or children who have attempted suicide or experienced suicidal ideation, even if they do have the capacity, due to fears of legal and liability issues.

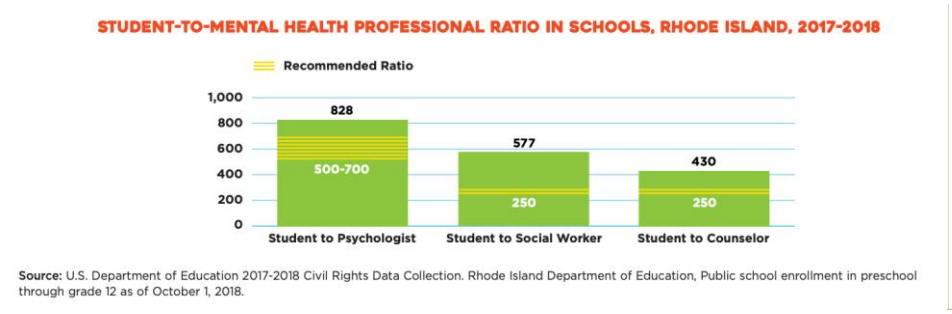
There are also significant workforce shortages of case managers, nurses, peer recovery specialists, and primary care and family physicians who can support mild to moderate mental and behavioral health needs.

The lack of community-based outpatient services is felt by other populations as well. The Department of Veterans Affairs (VA) Medical Center and Warwick Veterans Center report that Veterans' need for behavioral health services has outgrown their treatment capacity. To address this, they are increasingly referring Veterans to services in the community and are having trouble finding the services that their Veterans need.

More in-house behavioral health and psychiatric services for people with cognitive decline: CareLink has recently been funded to deliver in-home behavioral health services and psychiatric home supports to people with cognitive decline. However, more is needed across the State.

More mental health providers in school settings: Rhode Island's public school system does not have sufficient school counselors, psychologists, and social workers to give students the support they need. In 2020, the Rhode Island Department of Education (RIDE) received a five-year School-Based Mental Health Services grant to increase the number of qualified (i.e., licensed, certified, well-trained, or credentialed) mental health service providers that provide school-based mental health services to students in local educational agencies (LEAs) with demonstrated need. The Rhode Island Department of Education uses the SHAPE assessment and similar tools to help schools and districts strategically build comprehensive school mental health systems.

[37] Licensed mental and behavioral health clinicians include roles such as psychologists, masters-level counselors, clinicians, and therapists, clinical social workers, psychiatrists, and psychiatric nurse practitioners.



Source: U.S. Department of Education 2017-2018 Civil Rights Data Collection. Rhode Island Department of Education, Public school enrollment in preschool through grade 12 as of October 1, 2018.

The National Association of School Psychologists recommends a ratio of 500 to 700 students per school psychologist. The School Social Work Association of America recommends a 250-student per social worker ratio. The American School Counselor Association recommends a ratio of 250 students per school counselor. Rhode Island is above the recommended ratio across all categories.[38,39]

Beyond promoting mental wellness for all students, schools can also provide intervention services and treatment for students with additional mental healthcare needs. School-based mental health services are delivered by trained mental health professionals employed by schools, such as school psychologists, school counselors, school social workers, and school nurses. Providing mental health services in schools removes many barriers to mental healthcare access for students (e.g., transportation, scheduling conflicts, and stigma). Schools can provide school-based services and refer youth to more intensive resources in the community when needed. To this end, the FY24 state budget include a provision which requires that services provided by school social workers and certified school psychologists be included as health care related services eligible for federal Medicaid reimbursement.

More intensive home and community-based treatment programs: Interviewees noted that there are not enough home and community-based treatment, intensive outpatient treatment, partial hospitalization, and day treatment programs. This increases the demand for inpatient services and reduces the continuity of care post-discharge.

More residential and inpatient substance use treatment facilities: Interviewees noted insufficient residential and inpatient substance use treatment beds in Rhode Island, especially for pregnant or parenting people.

More long-term psychiatric residential beds: Stakeholders report that Rhode Island has an insufficient continuum of long-term, community-based residential psychiatric and substance use treatment beds and group homes, especially for people with serious and persistent mental illness, developmental disabilities, or comorbid behavioral health and medical concerns requiring skilled nursing facilities. In addition, the state lacks a secure, community-based residential facility for patients with self-harming tendencies and violent behavior. This gap in the current continuum impacts movement and flow throughout the system of care, preventing people from "stepping down" or "stepping up" to the most appropriate, least restrictive setting. It also often results in patients waiting for care in inappropriate settings, such as inpatient psychiatric beds. In turn, there are fewer beds for patients who need inpatient psychiatric care, so those patients wait for an inpatient psychiatric bed in a medical unit, resulting in fewer beds available in the medical unit for those needing medical care. As a result, there is tremendous pressure on inpatient units to free up beds, which can result in people being discharged inappropriately.

Increased staffing for inpatient psychiatric beds: A significant number of inpatient psychiatric beds are unavailable due to persistent staffing shortages across a range of occupations, including but not limited to psychiatrists, nurse psychiatrists, nurses, and support roles.

[38] While ratios are a reasonable benchmark of capacity, it is important that student and family need be the primary driver for determining needed staffing ratios.

[39] https://www.rikidscount.org/Portals/0/Uploads/Documents/Issue%20Briefs/11.22%20Mental%20Health%20Brief%20FINAL.pdf?ver=2022-11-15-121931-453

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Strategies

- Prioritize rate increases for behavioral health services to increase the availability of community-based licensed clinicians and psychiatrists participating in the insurance system.
- Increase the availability of community-based licensed clinicians and psychiatrists with expertise in caring for higher-risk populations, such as Veterans, survivors of domestic violence, and the LGBTQ+ population.
- Promote the integration of health/behavioral health in primary care settings by exploring sub-capitated Medicaid payment models for primary care practices to provide behavioral health services and address social determinants of health (SDOH) on an at-risk basis.
- Explore the feasibility of Medicaid authority and authorization to reimburse for group visits in medical settings to support cohort-based prevention services.
- Ensure the sustainability of the Pediatric Psychiatry Resource Network (PediPRN), which supports primary care providers in treating children and adolescents by offering same-day, specialized clinical consultations and resource/referral services related to mental health. This service enables providers to promptly, comprehensively care for their patients and avoid long wait times for specialized care.
- Advocate expanding Medicaid reimbursement for mental health services provided in schools.
- Explore models for making behavioral health services available through comprehensive, school-based health centers and school-based tele-behavioral health services.
- Increase the availability of in-home behavioral health and psychiatric services for people with cognitive decline.
- Ensure that Rhode Island's long-term, community-based residential care services have the capacity and specialization to treat populations with needs for co-occurring behavioral health treatment and other medically intense services.
- Increase the number of residential and inpatient substance use treatment beds in Rhode Island, especially for youth and pregnant people/parents.
- Address inpatient psychiatric staffing shortages across several occupations, including but not limited to psychiatrists, psychiatric clinical nurse specialists, nurses, and support roles.
- Increase the number of skilled nursing facilities caring for patients with behavioral health co-morbidities.

Goal 3: Provide rapid and remote access to help

Suicide hotlines play an important role in suicide prevention, counseling, and connecting patients to much-needed interventions and services. The recent implementation of the national 988 Suicide &Crisis Lifeline (988) is intended to:

- Provide enhanced access for people in behavioral health crisis through the use of an easy-to-remember three-digit number.
- Reduce reliance on the police by linking 988 centers with mobile crisis teams (for when the person in crisis requires services beyond what the call center itself provides).
- Reduce gaps in the existing fragmented behavioral health crisis care system by enabling 988 centers to stay in contact and follow up with those in crisis.
- Relieve emergency room boarding by providing needed evaluation and crisis intervention in the community whenever possible.
- Better meet the behavioral health needs of all people experiencing crises in a way that reduces stigma and encourages people at risk and their family members to seek help in the future.

988 was launched in Rhode Island in July 2022 and is staffed by BH Link. Both adults and children can call this line. Staff assess the caller for safety, identify the reason for the person's call, and then triage the caller. In a non-acute situation, this could include connecting the caller to resources and/or, if they are adults, getting them to a physical BH Link location for services such as a full clinical evaluation. If the staff are worried about the caller's imminent safety, they call a mobile crisis clinician and local police for a wellness check.

Key informants raised several concerns about the nationally established structure of the 988 lines. Specifically, 988 is not integrated with 911, so 988 cannot transfer calls to 911 in an emergency. Also, 988 does not have location services, so unlike 911, they cannot identify the caller's location in an emergency. In addition, Rhode Island callers who do not have a 401 area code (for example, an out-of-state college student) are rerouted to the area code in their phone number.

Key informants were also very concerned that 988 protocols in Rhode Island do not differentiate between adult and child callers. Pediatric clinicians noted that they would continue to refer their patients to Kids' Link

RI until there were protocols for children calling 988, and they had a better sense of how 988 staff were trained to handle calls from people younger than age 18.

They also recommended that the State increase its promotion of the line. In addition to 988, The Samaritans of Rhode Island offers a listening line for adults. The line is staffed by volunteers and isopen depending on the availability of volunteers to answer lines. The COVID-19 pandemic has made it difficult to consistently staff the line 24/7.

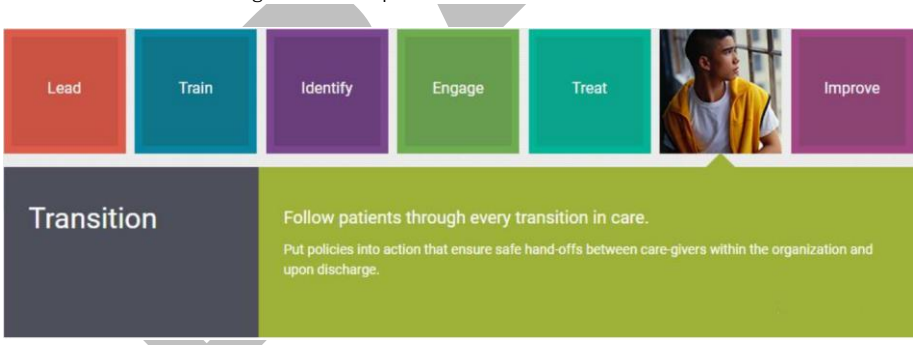
Strategies

- Work to integrate 911 and 988 call centers and responses, and advocate for geolocation of 988 calls to enable mobile response if needed.
- Ensure financial sustainability for 988 and support for crisis centers.
- Promote use of youth and adult peer recovery specialists as part of the mobile crisis response teams.
- Educate the public and increase the visibility of the 988 hotline, mobile crisis, and warm line resources in all communities statewide through posters and social media.
- Clarify protocols for callers to 988 who are younger than age eighteen, and ensure that staff are trained to take calls from children.

Goal 4: Create safer suicide care through systems change

Zero Suicide

The Zero Suicide model seeks to eliminate suicide among patients engaged with health systems. Zero Suicide was designed to improve suicide care, incorporating seven components (i.e., lead, train, identify, engage, treat, transition, improve) of a quality improvement model to transform how health systems care for people with suicidal thoughts and behaviors. Studies in Australia and the US have shown the effectiveness of the Zero Suicide model in reducing suicide attempts and ideation.[40]



There are several organizations and collaborations in Rhode Island using the Zero Suicide framework, including but not limited to the Washington County Healthy Bodies, Healthy Minds Health Equity Zone, which has had a Zero Suicide initiative funded through a Substance Abuse and Mental Health Services Administration (SAMHSA) grant. In addition, Certified Community Behavioral Health Centers are required to adopt this framework.

Systems-Level Triage Protocols for Veterans
There is also an opportunity to improve protocols for identifying Veterans and referring them to VA services. While not all Veterans are eligible for VA medical services, RIDOH and the Rhode Island Office of Veterans Services (RIVETS) are developing identification and screening protocols through an initiative called Ask the Question to identify persons who served in the armed services, screen for suicide risk, and connect them

[40] https://zerosuicide.edc.org/

with services (either with Rhode Island's Veterans Centers or, if they prefer, community-based services). The goal is to improve access to care for service members, Veterans, and their families. The initiative asks providers in civilian healthcare settings and community programs to ask patients, "Have you or a family member ever served in the military?". Asking this question can build rapport and connection with patients, help identify health concerns and exposures specific to military service, and present an opportunity to refer to VA services. 988 has also implemented a triage protocol in its phone system, where callers can press a button indicating they are a Veteran and be redirected to the Veterans Crisis Line.

System Changes to Prevent Suicide Among Law Enforcement
Studies suggest that suicide rates are particularly high among law enforcement occupations. Existing research suggests that officers may be more likely to die by suicide than in the line of duty.[41] Law enforcement officers are vulnerable to the same risk and precipitating factors for suicide as others in the general population, such as mental illness, substance misuse, social isolation, relationship problems, and legal and financial issues. Additional factors more specific to the law enforcement profession include exposure to suicide and other traumatic events (e.g., child abuse, violence, death of a colleague), easy access to firearms and skills in their use, and organizational stressors (e.g., shift work, administrative burden). Protective factors that appear particularly relevant to preventing suicide among police officers include access to culturally appropriate mental health and wellness services, resilience (particularly skills for coping with work-related stressors), and social support.

Law enforcement and rescue departments in Rhode Island are increasingly adopting practices to promote mental health and wellness and prevent suicide and related problems (e.g., employee assistance program services, traumatic incident response, and mental health policies). However, these practices vary dramatically across cities and towns. Municipalities would welcome technical assistance to create model policies and establish effective peer support models.

Strategies

- Build capacity to implement the Zero Suicide approach within all medical and behavioral healthcare settings and ensure the sustainability of existing Zero Suicide initiatives. Specifically:
    - Work with the Hospital Association of Rhode Island, the Rhode Island Health Center Association, and the Substance Use and Mental Health Leadership Council to commit to implementing Zero Suicide across their healthcare/behavioral healthcare organizations.
    - Organize statewide Zero Suicide Academies for healthcare leaders/teams to learn how to implement Zero Suicide with fidelity.
    - Develop a training and support infrastructure similar to Connecticutto support the adoption of Zero Suicide statewide.
    - Require universal, standardized screening for depression and suicidal ideation at every health/behavioral healthcare appointment.
    - Ensure the Certified Community Behavioral Health Centersimplement the Zero Suicide approach.
- Improve communication and care coordination protocols between the VA Medical Center and other hospital systems in Rhode Island. Specifically, continue to explore the feasibility of implementing the "Ask the Question" initiative at hospitals and behavioral health centers.
- Develop and share a model mental health policy for law enforcement and first responders.
- Require municipalities to have a mental health policy for law enforcement and first responders in place.

Priority 4: Promote healthy connections

The literature consistently depicts social connection and school connectedness as protective factors against physical and psychological disorders, all causes of mortality, and suicidal ideation and attempts. Social capital is related to connectedness and refers to a sense of trust in one's community and neighborhood, social integration, and the availability of and participation in social organizations. Together, connectedness and social capital may protect against suicidal behaviors by decreasing isolation; encouraging adaptive coping behaviors; and increasing a sense of belonging, personal value, and worth to help build resilience in the face

[41] https://www.theiacp.org/sites/default/files/2020-02/_NOSI_Issue_Brief_FINAL.pdf

of adversity. Connectedness and social capital can also provide individuals with better access to formal support and resources and mobilize communities to meet the needs of their members.[42]

Finally, schools can be especially well-suited to provide connectedness interventions that reach youth. Rich literature supports the association between school connectedness and reduced self-reported suicidal ideation or suicide attempt. Increased school connectedness is associated with reduced reports of suicidal thoughts and behaviors among adolescents, including adolescents who identify as sexual minorities and others, such as those residing in communities with an increased risk of suicide. Physical connectedness and social capital may protect against suicidal behaviors by decreasing isolation and encouraging adaptive coping. The research also suggests that school psychologists, school counselors, school social workers, and other student support personnel have an important role to play in facilitating school connectedness.[12]

Goal 1: Promote healthy peer norms

Promoting healthy connections among individuals and within communities through modeling healthy peer norms and enhancing community engagement may protect against suicide by normalizing protective factors for suicide, such as help-seeking and adaptive coping. Healthy peer norms can shift group-level beliefs and promote positive social and behavioral change. These approaches are often focused on youth, but they have also been implemented in community and military settings with demonstrated success.[12] In fact, peer support is a powerful resource for police in addressing stress management, mental health concerns, suicide prevention, and overall officer safety and wellness. It is important to note that the continued stigma around talking about mental health and suicide is a major barrier to implementing coping and problem-solving skills groups, despite the benefit to individuals across the lifespan.[12]

In Rhode Island, key informants spoke about the importance of integrating and expanding peer models in a variety of settings, including law enforcement and rescue, recovery centers, behavioral health treatment, inpatient settings, and community programs working with higher-risk populations, including but not limited to Veterans, LGBTQI+ populations, survivors of intimate partner violence, and people with prior incarcerations.

Strategies

- Disseminate best practices and support the implementation of peer models in the following settings:
    - Law enforcement and rescue settings (like the Connecticut Alliance to Benefit Law Enforcement peer support program(
    - Recovery centers
    - Behavioral health treatment
    - Inpatient settings
    - Youth settings and schools (e.g. the Peer2Peer model for middle and high schools)
    - Community programs working with higher risk populations including but not limited to Veterans, and LGTBQI+, survivors of intimate partner violence, and people with prior incarcerations

Goal 2: Engage community members in shared activities

Key informants stressed the importance of continuing to invest in ways that children and adults can engage in their communities. Community engagement builds social capital. Investing in opportunities for adults and children to become more involved in their communities and connect with other community members, organizations, and resources is important. Participation results in enhanced overall physical health, reduced stress, and decreased depressive symptoms, reducing the risk of suicide. Older populations are at higher risk for isolation.

Strategies

- Support and promote community wellness initiatives, prevention education, and positive youth development activities.

[42] Centers for Disease Control and Prevention (CDC). (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, CDC.

- Broaden the scope of suicide prevention to include the promotion of wellness and identify those community-based organizations, faith leaders, and agencies that might be well-positioned to develop programs that promote emotional well-being and connectedness.
- Support and promote activities that build a community for older adults.
- Promote, in partnership with the Department of Environmental Management, all of Rhode Island's outdoor parks (greenways) and public water access (blueways) connecting people to places of natural beauty.
- Continue public health campaigns to reduce the stigma that surrounds mental health.

Priority 5: Teach coping and problem-solving skills

Life skills are important in protecting individuals from suicidal behaviors and reaching key developmental milestones that impact psychological health, such as success at school and work. Teaching and providing youth with education and skills to manage everyday challenges and stressors is an important developmental component of suicide prevention. It can help prevent and/or mitigate suicide risk factors such as adverse childhood experiences (abuse and neglect), substance use, and more. Acquiring coping and problem-solving skills also occurs in adulthood and is beneficial. Adults often face new and challenging life events requiring additional education, coping, and problem-solving skills essential for maintaining well-being and protecting against suicide. For example, healthy parent-child relationships can promote safe, stable, nurturing family environments and relationships. [43]

Goal 1: Support social-emotional learning programs and support resilience through education programs

Studies from the U.S. and other countries demonstrate that social-emotional learning (SEL) programs are associated with positive outcomes, including reduced emotional distress, improved well-being, and better social and academic adjustment. SEL components related to suicide prevention and help-seeking reduce the stigma of discussing mental health and increase help-seeking behavior. SEL programs provide children and youth with skills to resolve problems in interpersonal relationships in all settings (including school) and help them address other negative influences, such as substance use associated with suicide.[44]

There are several school-based initiatives in Rhode Island aimed at promoting social-emotional learning and emotional regulation, including:

- The Rhode Island Violence and Injury Prevention Program (RIVIPP) has contracted with Rhode Island Student Assistance Services (RISAS) to provide a school-based peer-group program designed to enhance early adolescents' ability to apply emotion regulation skills and to decrease risk behaviors related to interpersonal and sexual violence. This group model was previously studied using Project Trac by a team of local researchers, including Chris Houck, Ph.D. from Rhode Island Hospital. Dr. Houck's work has shown that early adolescents participating in his emotion regulation programs are less likely to engage in risk-taking behaviors such as increased sexual activity and physical fighting. RISAS currently conducts school work groups through a model called Project Success, which includes prevention goals to reduce alcohol, tobacco, and other drugs and suicide prevention goals as part of the Department's RI Youth Suicide Prevention Program. RISAS has added an emotion regulation component to prevent and reduce interpersonal and sexual violence behaviors. Students participating in the group can practice: identifying, labeling, and monitoring emotions in themselves and others; recognizing the connection between emotions, behavior, and decision-making as well as the benefits of reducing the intensity of emotion; and regulating emotion during situations that evoke emotion. Participation in the intervention is through self-referrals and referrals made by school administrators, guidance counselors, teachers, parents, and friends.

- In June 2002, RIDE updated the Rhode Island Health Education framework to encompass social and emotional learning (SEL) and ensure that it is an integral part of the health education curriculum through which students can acquire and practice skills to establish and maintain positive relationships with others.

[43] CDC. (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[44] CDC. (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

- Since 2018, RIDE has secured seven grants from SAMHSA and USDOE that focus on school climate and culture. A Multi-Tiered Systems of Support Framework[45] guides the work. Mental well-being is an integrated component focused on building mental health literacy among faculty, staff, youth, and families and providing early identification and tiered interventions to those in need.

- The Woonsocket Education Department fully implemented teen Mental Health First Aid (tMHFA) which teaches teens in grades 10-12 or ages 15-18 how to identify, understand and respond to signs of mental health and substance use challenges among their friends and peers. This work could inform expansion to other districts.

- Also, ten of Rhode Island's 66 local education agencies are participating in the SAMHSA-supported Project Advancing Wellness and Resiliency in Education (Project AWARE), which aims to develop a sustainable infrastructure for school-based mental health programs and services by implementing mental health-related promotion, awareness, prevention, intervention, and resilience activities to ensure that students have access to and are connected to appropriate and effective behavioral health services. The program has increased mental health literacy among the schools and communities, removed barriers to finding care, and ensured cultural relevance for all school programs.

- Finally, EOHHS is currently leading a Taskforce charged with developing a state plan for strengthening Rhode Island's Infant and Early Childhood Mental Health (IECMH) system, which focuses heavily on early social-emotional development, early relational health, and attachment.

Strategies

- Support implementation of the RI Health Education Framework, including mandated instructional outcomes for mental health.
- Expand education on healthy relationships for youth and teens.
- Continue to support the expansion of school-based mental health initiatives across additional school districts to increase the capacity of school districts to create safe and secure environments.
- Encourage all school districts to implement teen Mental Health First Aid (tMHFA).
- Continue to support implementing a Multi-Tiered Systems of Support Frameworks in districts and schools to increase access to the core curriculum, including social and emotional learning and mental health school-wide.
- Support recommendations made through the Rhode Island IECMH planning process.

Goal 2: Teach parenting skills to improve family relationships

Parenting and family skills training approaches have well-established impacts in reducing common risk factors for suicide and strengthening family bonds, a protective factor against suicide. Rhode Island implements several evidenced-based voluntary parenting and family visiting programs that provide tailored services supporting parent and family skills and positive parent-child interactions. These include but are not limited to:

Program Name	Description	Who is Served
Nurse-Family Partnership	Focuses on improving three key areas: pregnancy outcomes, child health and development, and parent life trajectory	Mothers who are pregnant (70%) and first-time mothers facing adversity.
Healthy Families America	Program aims to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors	Expectant parents and parents/caregivers with children under three months of age who have one or more risk factors. Services are offered voluntarily and intensively until the child turns four.
Parents as Teachers	Program aims to increase parent knowledge of early childhood development and improve parenting practices, detect developmental delays	Services begin prenatally or immediately following the birth of a baby. They are offered voluntarily to parents/caregivers with children under three months of age with one or more risk

[45] https://www.mtssri.org/

Program Name	Description	Who is Served
	and health issues early, prevent child abuse and neglect, and increase children's school readiness and success.	factors. Services are provided intensively until the child turns four years of age (although some programs serve families with children up to age 5)
Family Care Community Partnership (FCCP)	Assists the family in identifying supports to help them in meeting their needs, both short and long term to help strengthen the family and build resiliency for long-term stability.	1) Families with children and youth who are at risk for child abuse, neglect, and or dependency and DCYF involvement; 2) children birth to age 18 years of age who meet the criteria for having a serious emotional disturbance; and 3) youth concluding a sentence at the RI Training School (RITS) who agree to participate, including youth leaving the RITS and youth leaving temporary community placement.
SafeCare	Parent-training program that supports parents/caretakers of children, birth to age five, with known risk factors for and/or a history of child neglect and abuse.	Parents of children birth to age five with known risk factors for and/or a history of child neglect and abuse.
Triple P (Positive Parenting Program)	Triple P is designed to teach positive strategies and parenting skills and their application to various target behaviors and settings.	Multi-stressed caretakers of children, birth to 12 years of age, and who exhibit behavioral or emotional difficulties, such as aggressive or oppositional behavior.
Incredible Years	Incredible Years® (IY) is a series of group-based programs for parents, children, and teachers to prevent and treat young children's behavior problems and promote their social, emotional, and academic competence. The Incredible Years Teacher Classroom Management Program (TCM) is an evidence-based prevention program designed to strengthen teacher classroom management strategies and to promote children's prosocial behavior and school readiness (reading skills). TCM will improve managing current and future classroom behavior problems; use effective classroom management strategies more frequently; will improve managing classroom behavior; and will increase parent engagement.	The Regional Prevention Task Force (RPTF) coalitions through funding from the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), have implemented the TCM program for preschool and kindergarten teachers. The Bradley Learning Exchange also offers early care and education providers professional development in IY. Preschool Development Block grant funds fund IY programming for parents in two Health Equity Zones.
Strengthening Families Program (SFP)	An evidence-based family skills training program for high-risk and general population families recognized nationally and internationally. Parents and youth attend weekly SFP skills classes together, learning parenting skills and youth life and refusal skills. They have separate class training for parents and youth in the first hour, followed by a joint family practice session in the second hour.	This program is free to Rhode Island residents through the Regional Prevention Task Force Coalitions.
Conscious Discipline	Conscious Discipline is a comprehensive emotional intelligence and classroom management system that integrates all learning domains (social, emotional, physical, cultural, and cognitive) into one seamless curriculum.	Conscious Discipline professional development is available for RIDE Pre-K Staff and administrators supported by PDG funding.

Most of these programs are available statewide but prioritized for specific cities and towns with higher concentrations of families facing significant adversity. A common pathway for accessing these programs is the Rhode Island First Connections program, a short-term, family visiting program for families with children from birth to age three that provides home and health assessments, developmental screenings, and connections to other community resources, including the long-term family visiting programs listed above. Due to funding constraints, none of these programs are available universally.

Strategies

- Expand access to voluntary short-term family visiting services for all Rhode Island families.
- Continue to invest in long-term family visiting programs, including Nurse-Family Partnership, Healthy Families America, and Parents as Teachers.

Priority 6: Identify and support people at risk

Gatekeeper training[46] and suicide risk screening and assessment are approaches that can identify and help people at increased suicide risk. Crisis response interventions, proactive planning and outreach interventions, and therapeutic approaches are intervention and treatment approaches to support disproportionately affected populations. Supporting at-risk people requires proactive case finding and effective response, crisis intervention, and evidence-based treatments. However, improving and expanding services does not guarantee those who need the services the most will utilize them. For example, some people living in communities experiencing risk may face social and economic issues that can adversely affect their ability to access supportive services. Interventions and treatments should be culturally sensitive and tailored to meet the needs of populations disproportionately impacted by suicide and suicide risk. Key priorities are to develop optimal ways of identifying individuals at risk, customize services to make them more accessible (such as leveraging telehealth services when appropriate), and engage people in evidence-based care.[15]

Goal 1: Strengthen Universal Screening and Train Gatekeepers

Gatekeepers can come from all sectors of the community. They can help prevent suicide by being trained to identify people at risk for suicide or suicidal behavior and to respond effectively by facilitating referrals to treatment and other support services. Gatekeepers could include peers, teachers, coaches, clergy, emergency responders, and primary and urgent care providers. This training may be implemented in various settings to identify and support at-risk people.

In Rhode Island, there are efforts in healthcare settings and schools to train staff to identify people at risk for suicide. However, there is an opportunity to more comprehensively train healthcare providers and staff at natural touchpoints[47] to screen for suicide universally.

Health Care Settings

RIDOH and the RI Veterans Administration are currently exploring the implementation of an initiative called “Ask the Question.” Through this initiative, healthcare providers ask patients, "Have you or a family member ever served in the military?" The broad language in the question purposefully casts a large net to include anyone with a military connection. It employs the "any, any, any" definition of a Veteran- any person who served in any military service branch (Army, Navy, Marines, Coast Guard.) The goal is to improve access to care for service members, Veterans, and their families. Asking this question can build rapport and connection with patients, help identify health concerns and exposures specific to military service, and present an opportunity to refer to VA services.

School Settings

Currently, the approach and scope of behavioral health and/or suicide screening vary by the school district, and it is not implemented universally. While the Nathan Bruno and Jason Flatt Act H5353, effective July 2,

[46] Gatekeeper training (GKT) is one of the most widely used suicide prevention strategies. It involves training people who are not necessarily clinicians to be able to identify people experiencing suicidality and refer them to appropriate services.

[47] Natural touchpoints are places like domestic violence crisis centers, legal services for immigrant populations, unemployment offices, employee assistance programs (EAP), providers, banks, justice systems, youth transitioning out of foster care, providers working with individuals newly diagnosed with chronic or serious mental or physical health problems, providers who work with the bereaved, such as funeral directors, individuals selling firearms and providing training in their use, and faith leaders.

2021, requires the training of teachers, students, and all school personnel regarding suicide awareness, how each district complies with the law varies. The Rhode Island Department of Education (RIDE) strongly encourages districts to utilize evidence-based tools when selecting curricula. It publishes an approved list of curricula that meet the Nathan Bruno and Jason Flatt Act requirements and the Annual School Health reporting requirements. In addition, each public school district must adopt a policy on student suicide prevention. RIDE partners with the Rhode Island Department of Health (RIDOH), the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), the Rhode Island Student Assistance Services Organization (RISAS), and the school districts to provide professional development for all school staff and volunteers, as well as model policy guidance to support the implementation of these requirements.

Ten districts are participating in SAMHSA ProjectAWARE, which aims to develop a sustainable infrastructure for school-based mental health programs and services by implementing mental health-related promotion, awareness, prevention, intervention, and resilience activities to ensure that students have access and are connected to appropriate and effective behavioral health services. SAMHSA expects this program to promote the healthy social and emotional development of school-aged youth and prevent youth violence in school settings.

In addition, there are several youth suicide prevention initiatives available to Rhode Island public schools. In 2015, Bradley Hospital Access Center, in partnership with RIDOH and RISAS, developed a coordinated youth suicide prevention referral system called the Suicide Prevention Initiative (SPI). SPI is a diversion protocol. Student support staff at participating schools receive training on the protocol, including screening using the Columbia Suicide Severity Rating Scale (C-SSRS) and referring them to Kids' Link RI (KidsLink). KidsLink evaluates the child and connects them with appropriate services. The goal is to divert at-risk students experiencing a mental health crisis from unneeded emergency room visits and inpatient services by connecting them to local mental health services with follow-up support. This system has grown every year -- it began with five school districts and now has been adopted in fifteen districts (some of the same districts that are also doing ProjectAWARE). The capacity of KidsLink constrains the ability to grow the SPI program. School districts report having difficulty getting slots for evaluation or beds when they use the SPI process because KidsLink's evaluation capacity is limited, and available inpatient beds are also limited. However, when it works, schools report it is a positive experience. Forty percent (15 out of 36) of municipal school districts participate in SPI. In addition, RIDE has received 2 grants from the United States Department of Education (USDOE) to fund school-based mental health services in 6 additional districts.

52% of the school districts participate in either SPI or ProjectAWARE. The table below crosswalks LEA participation in SPI, ProjectAWARE, the USDOE-funded mental health services, and Rhode Island Student Assistance Services (see page 6 for more information).

It should be noted that the requirements of the Nathan Bruno and Jason Flatt Act are an unfunded mandate, and school districts are trying to use existing resources to support the implementation of all of the requirements and grapple with growing mental health needs among their students.[48] The level of need varies by school, and even districts participating in SPI and/or ProjectAWARE may struggle to meet their students' growing mental health needs.

Table: Participation in SPI, ProjectAWARE, and RISAS Student Assistance by municipal/regional district

School District	SPI	ProjectAWARE	ProjectSUCCESS	USDOE funded mental health services	Mobile Crisis Response
Barrington			X		
Bristol Warren	X		X		
Burrillville			X		
Central Falls	X		X	X	X

[48] The 2021 Rhode Island Youth Risk Behavior Survey (YRBS) show that there has been a significant increase in serious thoughts about suicide and suicidal attempts among young Rhode Islanders since 2011. For example, during that period: 1) the percentage of high school students seriously considering attempting suicide increased from 12.3% to 17.1%, and 2) the percentage of high school students that made plans to attempt suicide increased from 10.7% to 14.5%.

School District	SPI	ProjectAWARE	ProjectSUCCESS	USDOE funded mental health services	Mobile Crisis Response
Chariho		X	X		
Coventry			X	X	
Cranston		X	X		X
Cumberland			X		
East Greenwich					
East Providence	X	X	X		X
Exeter-West Greenwich	X		X	X	
Foster-Glocester			X	X	
Jamestown					
Johnston	X		X	X	
Lincoln			X		
Little Compton					
Middletown			X		X
Narragansett	X		X		X
Newport	X	X	X		X
New Shoreham			X		
North Kingstown	X		X		X
North Providence			X		
North Smithfield			X		
Pawtucket	X	X			X
Portsmouth	X		X		
Providence	X	X	X		X
Scituate	X		X	X	
Smithfield			X		
South Kingstown	X		X		X
Tiverton			X		
Warwick	X	X	X		
Westerly		X	X		
West Warwick		X	X		X
Woonsocket	X	X	X		X

Finally, the RI Student Assistance Organization (RISAS) offers training to the community in QPR (Question, Persuade, Refer), an evidence-based training on the warning signs of suicide and how to refer a youth for help.

This free training is available to community-based organizations, parents, and other groups. A one-hour training focused on "gatekeepers"—people in a position to recognize a crisis and do something about it. A gatekeeper can be a friend, coworker, teacher, boss, or parent.

Strategies

- Ensure that all districts implement RIDE's LEAP recommendations[49] to screen all students for social-emotional health universally.
- Promote universal suicide screening at natural touchpoints where individuals may be experiencing unanticipated or stressful transitions (e.g., domestic violence crisis centers, faith-based organizations, legal services for immigrant populations, unemployment offices, employee assistance programs, banks, justice systems, providers who work with the bereaved, such as funeral directors, individuals selling firearms and providing training in their use, and via targeted outreach to individuals experiencing heightened stress, e.g., youth transitioning out of foster care, providers working with individuals newly diagnosed with serious and/or chronic health problems.
- Increase suicide prevention awareness campaigns at natural touchpoints where people may be experiencing unanticipated or stressful transitions (see list above).
- Integrate suicide prevention into training for staff and volunteers who may encounter individuals at natural touchpoints where people may be experiencing unanticipated or stressful transitions (see list above).
- Consider strategies for building the capacity to universally screen for suicide ideation in schools, e.g., expand the capacity of student assistance within districts or use mobile screening teams to expand the school's capacity to screen for behavioral health issues and suicide.
- Advocate expanding Medicaid reimbursement for mental health services provided in schools.
- Continue to promote the use of evidence-based youth suicide prevention curricula.
- Sustain and expand the SPI program to all districts in the state and expand the capacity of KidsLink to scale the program.

Goal 2: Respond to crises

When a crisis occurs, it is important to provide real-time support, risk assessment, and referral to emergency services or treatment. Typically, a person in crisis (or a friend or family member of the person at risk) is connected to trained volunteers or professional staff via a telephone hotline, online chat, text messaging, or in person. Crisis response interventions are intended to reduce key risk factors for suicide, including feelings of depression, isolation, and hopelessness, and promote subsequent mental healthcare utilization. Crisis response interventions can put space or time between an individual who may be considering suicide and harmful behavior.[50]

Like most states, rescue services and/or law enforcement are often the first responders to most crises in Rhode Island. Crisis Intervention Teams (CIT) is a program that brings together mental health service providers and law enforcement officers to assist persons with behavioral health disorders (e.g., mental illness, developmental disabilities, Alzheimer's disease, and substance use disorders). The most important aspect of the CIT Program is the 40-hour training provided to law enforcement officers. The effort aims to improve safety, reduce arrests, improve the use of emergency psychiatric assessment, and avoid over-reliance on emergency room visits. Every district (county) within Rhode Island has at least one police department with at least one employee who has received CIT training. However, more training is needed, not just for law enforcement officers but also for rescue personnel. While the training is grant-funded, municipalities must pay personnel to fill in for the person in training. This is costly (approx $2,200 per person).

Another component of Rhode Island's crisis response system is a triage facility for adults called BHLink. BHLink is located in East Providence and intended to connect people to immediate, stabilizing emergency behavioral health services and long-term care and recovery supports. Interviewees stressed the importance of triage facilities to provide stabilizing services and divert patients, where appropriate, from the emergency room. They also made several recommendations for improvement:

- **Locate the facility in a more central location or open multiple locations in different areas of the state:** A main concern is that the current location deters law enforcement and rescue services from

[49] https://www.ride.ri.gov/Portals/0/Uploads/Documents/COVID19/LEAPTaskForceReport.pdf?ver=2021-04-28-150118-777
[50] CDC. (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

bringing people to the facility. Its location in East Providence is difficult to get to from many areas of the state and especially during rush hour, even from adjacent cities like Providence. It can take three hours round trip from Westerly to take someone there and at least 2 hours in rush hour from parts of Providence. When municipalities dispatch a law enforcement or rescue team to bring a resident to BHLink, they must pay for backfill coverage in their town while their staff is deployed to BHLink. Law enforcement is not equipped to handle crises arising during the trip (e.g., blackouts, seizures, self-harm, etc.), so they are reluctant to transport people long distances. As a result, law enforcement and rescue from most areas of the state avoid bringing people to BHLink (even those located in Providence.)

- **Shorten the assessment time and eligibility requirements:** Another reason that law enforcement and rescue are reluctant to bring people to BHLink is the screening and assessment requirements. They must call ahead and report waiting for 30+ minutes to find out if BHLink will accept the patient. There is also a perception that BHLink has very rigid rules for who they will take - another deterrent for law enforcement. Finally, BHLink often does not come up as an option unless the patient knows about it or the rescue provider is knowledgeable enough to suggest it to the patient (or wants to suggest it) this significantly limits the utilization of BHLink by people who require rescue services or law enforcement involvement.
- **Increase the capacity:** There is a perception that BHLink frequently discharges people back to emergency rooms because they cannot provide the appropriate level of care or are at capacity.
- **Strengthen post-discharge follow-up and care coordination:** Some interviewees shared that people who have used the BHLink service report that there is little to no follow-up after discharge from BHLink.

Rhode Island also recently implemented mobile response and stabilization services (MRSS) for children and youth. In May and June 2022, Rhode Island used funding from RIDE to create a small MRSS project with vendors, Family Services of Rhode Island (FSRI) and Tides Family Services. MRSS aims to provide immediate, appropriate, in-person care and follow-up to children and families in crisis to prevent as many children as possible from seeking institutional care. Referrals are accepted and responded to 24/7, 365 days per year. The response team includes at least two people - a masters-level clinician and a paraprofessional. Follow-up interventions, coordination, and case management are provided up to 30 days after the initial assessment - and the services can go beyond 30 days if there is nowhere more permanent to care for the patient. Transitional discharge planning and involvement with the family remain in place until there is a secure connection to the services within the Children's Behavioral Health system of care.

For the initial building block program, the Executive Office of Health and Human Services (EOHHS), RIDE, and the participating vendors partnered with the Providence Public School district to ensure wraparound support for children receiving mobile response support services at home and school. In November 2022, EOHHS expanded this program with $5 million in Home and Community Based Services (HCBS) funding. EOHHS reached out to 12 high-need districts across the states (EOHHS worked with RIDE to identify which districts should be prioritized given limited funding). EOHHS will work closely with 988, RIDE, and DCYF to ensure that referral and triage protocols are aligned and connected. Additional SAMHSA funding will allow the state to continue to expand MRSS for children until the state's Certified Community Behavioral Health Clinic (CCBHC) program starts in February 2024 (if approved by the legislature). At that time, MRSS will transition to become a required service for Certified Community Behavioral Health Clinics funded through Medicaid reimbursement.

In addition, Newport and East Bay Mental Health have started a new program called Rhode Island Outreach, based on the CAHOOTS model. The CAHOOTS response team includes a crisis intervention worker skilled in counseling and de-escalation techniques and a medic who is either an EMT or a nurse. This pairing allows CAHOOTS teams to respond to a broad range of situations.

Strategies

- Continue to find ways to expand investment in Crisis Intervention Training (CIT) for both law enforcement and rescue and make the training affordable and accessible to municipalities.
- Continue to expand investments in diversion strategies (e.g., mobile crisis and BHLink) and address areas for improvement.
- Ensure that the mobile crisis referral and triage protocols are aligned with existing programs and systems like SPI, Project AWARE, law enforcement, rescue services, and BHLink.

Goal 3: Plan for safety and follow-up after an attempt

Preventing suicide reattempts includes safety and crisis response planning, follow-up contact, and brief contact interventions leveraging diverse modalities such as home visits and phone outreach. These strategies are designed to help individuals get treatment after attempting suicide. They can also increase adherence to treatment and promote continuity of care.[51] Interventions that support engagement and safety during care transitions are critical to suicide prevention. Safety planning is one example of proactive planning. Safety planning involves outlining what to do during a crisis, including steps for identifying personal warning signs, using coping strategies, activating social support, and accessing professional services. Follow-up contact and brief contact interventions are two examples of proactive and ongoing outreach approaches. Follow-up contact strategies use postcards, letters, text messages, and telephone calls to express care and support for individuals and typically invite individuals to reconnect with their providers.

The efficacy of transitions and discharge planning for suicide care varies widely in Rhode Island. Often discharged individuals wait 6+ weeks for an appointment with an outpatient clinician. In the meantime, during that period (the highest risk period), they may get little to no support or caring contacts unless they have access to a Zero Suicide peer. Having peer support while an individual is waiting for outpatient services is critical. In addition, the absence of clinical support during this time puts an enormous burden on the peer to help the individual get through the transition without clinical support. Also, very few discharged individuals receive support from community health workers to address social determinants of health (SDOH). More needs to be done to support individuals post-discharge after a suicide attempt.

Strategies

- Develop clear plans and hand-off protocols between all levels of intervention to support coordinated and continuous care and ensure the safety and well-being of all individuals assessed and treated for suicide risk.
- Ensure adequate and responsive after-care, especially post-discharge from acute care:
    - Encourage health and behavioral healthcare providers to utilize caring contacts (e.g., follow-up calls, texts, and cards) to support connections to care and prevent future suicide attempts.
    - Explore models for intensive care transitions that connect people to services and supports in their home communities upon discharge from a psychiatric inpatient setting.
- Create strong partnerships between community providers and hospitals to assist with continuity of care.
- Use data on EMS runs and ED visits for attempted suicides to deploy outreach workers for follow-up.

Goal 4: Provide therapeutic approaches

Therapeutic approaches include various forms of suicide prevention-focused psychotherapy delivered by clinically trained providers. They address underlying mental health disorders and suicide risk factors such as poor problem-solving and emotional regulation skills[52].

In addition to clinician shortages and long wait times for outpatient services, Rhode Island does not have enough clinicians trained in suicide prevention-focused psychotherapy. According to key informants, of those that are trained, very few currently participate in the insurance system meaning their services must be fully paid for out-of-pocket. Examples of evidence-based therapies include but are not limited to Cognitive Behavioral Therapy (CBT), Collaborative Assessment and Management of Suicidality (CAMS), Safety Planning (using the Stanley Brown instrument), and Dialectical Behavior Therapy (DBT).

Strategies

- Increase the number of available Rhode Island clinicians able to provide suicide prevention-focused psychotherapy, such as Cognitive Behavioral Therapy (CBT), Collaborative Assessment and Management of Suicidality (CAMS), Safety Planning (using the Stanley Brown instrument), and Dialectical Behavior Therapy (DBT).

[51] CDC. (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[52] CDC. (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Priority 7: Lessen harms and prevent future risks

Many people are bereaved by suicide yearly. The risk of suicide can increase among people who have lost a friend or peer, family member, coworker, or another close contact to suicide. The potential long-term effects among survivors are not currently well understood. However, public messaging and media reporting are important in preventing and reducing future suicide risks. For example, targeted media campaigns can increase exposure to protective factors by promoting resiliency and encouraging help-seeking behaviors. Research also suggests that media can play a role in increasing exposure to risk factors e.g., reports of suicide that include sensational or otherwise uninformed reporting can inadvertently contribute to what is known as suicide contagion.[19]

Goal 1: Intervene after a suicide (postvention)

One approach that can lessen harm and prevent future risk of suicide is postvention. Postvention happens after a suicide has taken place. It is an important preventive measure that may reduce future suicide risk by proactively and comprehensively supporting the needs of loss survivors. Postvention efforts may involve key partners in the community, such as first responders, mental health and healthcare providers, social service providers, faith leaders, local community leaders, and persons with lived experience. Postvention may include debriefing sessions, counseling, and/or bereavement support groups for surviving friends, family members, or other close contacts.

Rhode Island has limited postvention services, especially in the area of bereavement support groups for surviving friends, family members, or other close contacts. Currently, there are three available services, and they do not appear to be widely known:

- Wood River Health, as part of the Washington County Zero Suicide program, sponsors the state's only support group for survivors of suicide attempts (SOSA). This initiative is grant funded. The funding will end September 2023.
- Friendsway offers specialized bereavement groups for children and teens affected by suicide. Volunteer clinicians facilitate these groups, but several factors limit their capacity: 1) the number of volunteers available; 2) physical space (note: they are currently at capacity); 3) the location of their building, which is in Warwick and not easily accessible to many parts of the state; and 3) the lack of bilingual volunteer clinicians to facilitate groups in languages other than English.
- The Samaritans offer the Safe Place program, Rhode Island's only adult bereavement support group for people grieving the loss of a loved one to suicide. The meetings are held in Providence.

Strategies

- Sustain financial support for the Survivors of Suicide Attempts (SOSA) support group.
- Establish more geographically accessible bereavement support groups in RI. Ensure services are multi-lingual, culturally sensitive, and meet the needs of different age groups.
- Help to integrate suicide prevention efforts across sectors and settings, like faith- and community-based organizations, by providing a postvention toolkit for faith leaders and local community leaders to support them in providing comfort to those affected by suicide.
- Support implementation of trauma response teams of trained volunteers who provide supportive services to agencies, businesses, and/or informal groups who have experienced a recent death by suicide, sudden traumatic loss, or other traumatic incidents. Volunteers have received training in healthy processing, Mental Health First Aid, and/or have other related skills.

Goal 2: Report and message about suicide safely

A second approach that can lessen harms and prevent future risk of suicide is safe messaging and reporting about suicide. Public messaging about suicide prevention is a key communication strategy for educating individuals about warning signs and resources available to help individuals at risk for suicide before a crisis occurs. Safe messaging emphasizes that suicide is preventable and promotes actions and resources for prevention. Safe reporting following a suicide is critical. Reporting that sensationalizes suicide or glamorizes the person who died by suicide and the venue in which information about a suicide is shared (like during school

assemblies) can heighten the risk of suicide among at-risk individuals and can inadvertently contribute to suicide contagion.

There is no central coordination of safe reporting following a suicide in Rhode Island. Several key informants shared anecdotal stories of poor messaging and communication in their communities after a death by suicide.

Strategies

- Provide a postvention toolkit to schools, communities, and the media that offers comprehensive, practice-informed, and evidence-based guidance when responding to a death by suicide.

Priority 8: Build Rhode Island's suicide prevention infrastructure

State-level coordination of suicide prevention is important to ensure that prevention strategies implemented within communities address the people at highest risk for suicide and are comprehensive in scope.[53]

Goal 1: Establish multi-sectoral partnerships to plan and implement suicide prevention efforts

Suicide prevention cannot be a one-person or single-agency effort. While public health and behavioral health agencies are well primed to take on a leadership role and convene stakeholders, build capacity (e.g., support coalitions, develop training resources), and expand suicide prevention efforts, partnerships across a broad set of community partners such as prevention coalitions, task forces, or multi-agency work groups, is essential to build commitment and ownership.

Ultimately, agencies working in clinical health, mental health, substance abuse, education, justice, Veterans, health care, healthy aging, school systems, and private sector groups need to be involved and play a role in developing and implementing the plan. Engagement from groups at the highest risk for suicide (e.g., representatives LGBTQ+ communities, suicide attempt survivors, and survivors of suicide loss) are essential participants in any planning effort. Ideally, a convening agency with at least one position to support suicide prevention in the State should serve as the lead author and manage a State's suicide prevention plan to ensure a coordinated effort. Without sustained leadership and infrastructure, well-intentioned suicide prevention activities can be fragmented and non-strategic and thus unable to achieve sufficient range, depth, or focus on having a measurable impact on reducing suicides or suicide attempts.

Currently, Rhode Island does not have a dedicated group of stakeholders focused solely on suicide prevention.

It should also be noted that Rhode Island has a number of renowned suicide prevention researchers working at Brown University. Their expertise can be utilized to train Rhode Island's workforce and provide consultation.

Strategies

- Convene a coalition of stakeholders focused on suicide prevention and meet regularly to engage in strategic discussions and facilitate partnerships and information sharing.
- Leverage the outreach capacity of the regional Prevention Coalitions to facilitate suicide prevention efforts.
- Foster partnerships with suicide prevention researchers and faculty at Brown University and other institutions of higher education to provide training and foster the adoption of best practices in RI.
- Explore the possibility of partnering with Brown University to host an annual conference focused on suicide prevention.

Goal 2: Enhance the state's capacity to use data to inform suicide prevention efforts

State suicide prevention plans should be data-driven, living documents. Data on suicide and suicide attempts, including suicidal behavior among people receiving care in behavioral health care systems, should be

[53] https://sprc.org/sites/default/files/State%20Suicide%20Prevention%20Plans%20and%20Leadership%20Guidance.pdf

monitored and analyzed regularly. Rhode Island has several sources of data to help inform suicide prevention planning and conduct surveillance including:

- Mortality data from the Rhode Island Violent Death Reporting System (RIVDRS)
- Morbidity data from quarterly hospital discharge data and real-time (every 24 hours) emergency room visit data
- Self-reported data from the BHDDH Rhode Island Student Survey
- Self-reported data from the BHDDH Rhode Island Young Adult Survey (RIYAS)
- Self-reported data from the RIDOH high school and middle school Youth Risk Behavior Survey (YRBS)

Each source has its strengths and limitations. For a more comprehensive description of each data source, its strengths, and its limitations, please see the Appendix.

As a small state, Rhode Island is limited in how it can report data related to suicide mortality and morbidity due to its small numbers policy. Counts under five must be suppressed due to privacy and reliability concerns. With approximately 100 deaths by suicide per year, this makes it difficult to report on or analyze mortality data for disparately affected populations such as individuals identifying as LGBTQ+, experiencing intimate partner violence or homelessness, or with prior involvement in the criminal justice system. It is also difficult to understand patterns in deaths by suicide on bridges unless multiple years of data are aggregated.

Another challenge is understanding patterns in morbidity data for numerically small but disparately affected populations and priority populations such as Veterans because the information is not routinely captured in hospital records or included in the hospital discharge data sets shared with RIDOH. Expanding what is captured in morbidity data and required for hospital reporting would provide Rhode Island with the data that are needed for a deeper understanding of patterns among disparately affected and priority populations.

Strategies

- Strengthen data collection and sharing to enable a better understanding of patterns amongst priority populations and numerically small but disparately affected populations, including but not limited to:
    - Veterans
    - Individuals experiencing housing instability
    - Individuals identifying as LGBTQ+
    - Survivors of intimate partner violence
    - Individuals with involvement in the criminal justice system

APPENDIX: DESCRIPTION OF DATA SOURCES

Mortality Data: The Rhode Island Violent Death Reporting System (RIVDRS) provides data on all violent deaths in Rhode Island. Data reflect violent deaths (suicides, homicides, undetermined deaths) occurring in Rhode Island. The city or town where the death occurred may differ from the city or town where the individual was pronounced dead. If the location of the incident was not in Rhode Island or is unknown, the death is not usually included in a geographical count. Variations in unknown city of the incident may impact trends. Rhode Island residents who died of a violent death outside of Rhode Island are omitted.

Compared with available morbidity data, mortality data are generally more completely reported. Legally, all deaths have to be recorded and a death certificate issued. It is also more comprehensive. Deaths resulting from suicide are usually investigated and more information is collected than on nonfatal attempts. Information from all death certificates becomes part of the national Vital Statistics Records system. This system produces public information that can be easily accessed online and is also used as the basis of many reports and analyses. But mortality data provide an incomplete picture of the problem of suicidal behavior because most suicide attempts do not result in death and, by definition, are not included in mortality data.

In addition, despite better reporting than morbidity data, not all suicides are reported. Sometimes there is not enough information to determine intent. Without conclusive evidence, potential suicides may be recorded as unintentional or undetermined on death certificates. Even if the subsequent investigation determines that the death was a suicide, the death certificate may not be updated to reflect this finding. Medical examiners, coroners, doctors, and public safety professionals may not record a death as a suicide to spare the victim and their family the social stigma sometimes associated with a death by suicide (or to avoid other consequences such as voiding the victim's life insurance and thereby denying benefit's to the victim's family). Inconsistent case definitions about what determines a suicide create difficulty in coding mortality data.

Morbidity data: Rhode Island has two data sources on medically-treated, nonfatal suicide attempts. All hospital systems in Rhode Island report discharge data on hospital visits every quarter. Hospital visits that are self-harm or suicide-related are identified using specific criteria. However, interpreting this data is challenging because it is hard to determine intent. Rhode Island also has syndromic surveillance data. All acute care hospitals send emergency room visit data every 24 hours to RIDOH through a system called ESSENCE. Epidemiologists at RIDOH monitor this data using a syndrome algorithm developed by the CDC based on the chief complaint when presenting to the emergency room and discharge diagnosis. Visits that meet the criteria are flagged, and the data is used to monitor patterns. While these data potentially provide a complete picture of the problem of suicidal behavior, because most suicide attempts do not result in death, they are still less completely reported. While psychologically serious, many suicide attempts are not medically serious enough to require medical attention and do not get reported/coded. Some attempts that do require medical attention are also not coded as suicide attempts. Also, while hospital datasets are more accessible for public health surveillance than data from private physicians, clinics, and health maintenance organizations, hospital data may under or over-represent certain sub-groups. For example, lower-income people are more likely than higher-income people to use emergency departments to care for lower-severity medical problems. As a result, hospital data may over-represent suicide attempts among lower-income people. People who are treated for a suicide attempt at a psychiatric facility or a Veteran's Affairs medical facility will also not be captured by hospital discharge data, as these facilities do not participate in the Uniform Hospital Discharge Data System.

Self-Reported Data: Rhode Island also has self-reported data on suicidal behavior. This data provides a complete picture of individuals suffering from suicidal feelings or behaviors and can be useful for evaluating trends over time. Because suicide is a relatively rare event, it is difficult to measure the impact of a suicide prevention program on mortality data, particularly at the local level. Nonfatal attempts and suicidal ideation are far more frequent and, therefore, more sensitive to changes over time. However, it is more difficult to collect data accurately about how people feel or think versus how they behave, and self-reported data are subject to reporting biases. For example, high school students are asked on the Youth Risk Behavior Survey if they ever seriously considered suicide. This question is subject to recall bias (not all people will remember), social desirability bias (not all will want to admit suicidal feelings, even on an anonymous survey), and definition issues. After all, what is meant by "seriously" considered suicide? Mental Health America also conducts an annual survey and publishes state rankings on several mental health variables.

APPENDIX: KEY INFORMANTS

Nicolas Ferro	Social Worker	Building Futures
Katelyn C. Affleck, PhD	Lead Psychologist	Lifespan Physician Group Bradley Hospital
Sibel Algon, M.D.	Attending Psychiatrist	Bradley Hospital Outpatient Services, Adolescents
Denise Alves	East Bay Regional Task Force Coordinator	Barrington Prevention Coalition
Jillian Angel	Coordinator, RI Tobacco Control Program	Rhode Island Department of Health
Arnaldo Berges, MD	Assistant Chief of Psychiatry and Director of Adult Inpatient Psychiatry	Rhode Island Hospital
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Michelle Brophy	Associate Director Interdepartmental Services/Vulnerable Populations	RI Dept of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH)
Lisa Carcifero	Regional Director	Blackstone Valley Prevention Coalition
Brittany Church	Medicaid State Plan Coordinator	Rhode Island Executive Office of Health and Human Services
Brenda Clement	Director	HousingWorks RI
Tara Cooper	Chief	Center for Health Promotion, Rhode Island Department of Health
Kerrie Constant	Director	American Foundation for Suicide Prevention
Melissa Cotta, RN, MSW	Founder	RI Bridging the Gap
Jay Cordova	Fellow	National Academy for State Health Policy (NASHP)
Maria Crimini	Director	Rhode Island Office of Healthy Aging
Sarah Dinklage	Chief Executive Officer	RI Student Assistance Services
Tricia Driscoll	Executive Director	Center for Mediation and Collaboration RI

Kim Ferrante	Community Engagement and Partnership coordinator	Providence VA Medical Center
Elizabeth Farrar	Associate Administrator	Office of Prevention, RI Dept of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH
Ruth Feder	Interdepartmental Project Manager	RI Dept of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH)
Karen Flora	Project Director	RI Dept of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH)
Rochelle Fortin	Director	Warwick VA Center
Bryan Ganley	Founder	RI Bridging the Gap
Michele Gessman, LICSW	Clinical Director	Social Work and Counseling, Bradley's Children's Inpatient Program Team
Melissa Goldstein	Program Director	Bristol County Health Equity Zone
Erin Goodman	Peer Recovery Specialist	Washington County Zero Suicide Program
Rob Harrison	Director	Washington County Zero Suicide Program
Heidi Hartzell	Policy and Partnerships Specialist	Rhode Island Department of Health
Kate Hawley	Community Champion	Bristol County Health Equity Zone
Laurie Heydon	Community Champion School Psychologist	Bristol County Health Equity Zone Bristol-Warren School District
Melissa Holcomb	Administrator	RI Dept of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH)
Amy Hulberg	Medicaid Policy Director	Rhode Island Executive Office of Health and Human Services
Jeffrey Hunt, M.D.	Director of Inpatient and Intensive Services	Bradley Hospital
Colleen Judge	Director, School-Based Services	RI Student Assistance Services
Cory King	Acting Health Insurance Commissioner	Office of the Health Insurance Commissioner
Jacquiline LaFontante	Senior Planning & Program Development Specialist	Office of the Child Advocate
Don LaLiberte, LICSW	Assistant Director	Access, Lifespan Behavioral Health Emergency Services (includes KIDSLink)

Beth Lamarre	Director	National Alliance on Mental Illness Rhode Island
Ryan Loiselle	Program Director	FRIENDS WAY
Kathleen Kemp, Ph.D	Director	Rhode Island Family Court Mental Health Clinic
Zach Kenyon	Chief of Rescue	Providence Fire Department
Ian Knowles	Director	RICARES
Thomas Martin	Director, Division of Behavioral Healthcare	RI Dept of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH
Marybeth MacPhee	Community Champion/ Professor of Public Health	Bristol County Health Equity Zone Roger Williams University
Hannah Meharg	Associate	Rhode Island Prevention Resource Center (RIPRC)
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Rachel Morse, MSHS, CPS	Co-Director	Rhode Island Prevention Resource Center (RIPRC)
Weayonnoh Nelson - Davies, J.D.	Executive Director	Rhode Island Economic Progress Institute
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John Patton	Founder	Matthew Patton Foundation
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James Rajotte	Chief Strategy Officer	Rhode Island Executive Office of Health and Human Services
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Ellen Reynolds	Assistant Vice President, Student Health and Wellness and the Director	University of Rhode Island Health Services

Rosemary C Reilly-Chammat	Associate Director for School Health and Extended Learning	Rhode Island Department of Education
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Tim Ruel	Employment and Training Case Manager	Operation Stand Down
Paul Santilli, LICSW	Counselor	Warwick VA Center
Catherine Schultz	Director of Governor's Overdose Taskforce	Rhode Island Executive Office of Health and Human Services
Jeanne Smith, LICSW	Suicide Prevention Coordinator	Providence VA Medical Center
Tyrone Smith	Director of Employment and Training	Operation Stand Down
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Shannon Spurlock, MA, CPS	Co-Director	Rhode Island Prevention Resource Center (RIPRC)
Kathy Sullivan	Program Director Advanced Certified Prevention Specialist	The BAY Team, Rhode Island Prevention Resource Center Rhode Island Student Assistance Services
Patricia Sweet	Director of Region 1 Prevention Coalition	Tri-County Community Action Agency
Andy Taubman, MSW	Director of Youth Service	Youth Pride

Jo-el Tillinghast	988 Community Network Coordinator ·	Community Care Alliance
Lisa Tse	Interdepartmental Project Manager	Rhode Island Executive Office of Health and Human Services
Hailey Voyer	Public Health Epidemiologist	RI Dept of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH)
Kristen Westmoreland	Co-coordinator	East Bay Regional Task Force
Jennifer Wolff, M.D.	Staff Psychologist/Researcher on Suicide	Lifespan Physician Group Bradley Hospital
Gracie Woodcock	Community Champion	Bristol County Health Equity Zone
VIctor Woods	Health Economic Specialist	Office of the Health Insurance Commissioner