Rhode Island

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 12/11/2023 2.32.36 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year 2024

End Year 2025

State SAPT Unique Entity Identification

Unique Entity ID LWPVXFL8DS51

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

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

Organizational Unit Division of Behavioral Health

Mailing Address 14 Harrington Road

City Cranston

Zip Code 02920

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

First Name Louis

Last Name Cerbo

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

Mailing Address 14 Harrington Road

City Cranston

Zip Code 02920

Telephone 401-462-2339

Fax

Email Address Louis.cerbo@bhddh.ri.gov

State CMHS Unique Entity Identification

Unique Entity ID LWPVXFL8DS51

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

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

Organizational Unit Division of Behavioral Health

Mailing Address 14 Harrington Road

City Cranston

Zip Code 02920

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

First Name Louis

Last Name Cerbo

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

Mailing Address 14 Harrington Road

City Cranston

Zip Code	02920
Telephone	(401)462-2239
Fax	
Email Address	louis.cerbo@bhddh.ri.gov

III. Third Party Administrator of Mental Health Services

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

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

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

From	
To	

V. Date Submitted

Submission Date	8/31/2023 3:32:32 PM
Revision Date	12/11/2023 2:32:25 PM

VI. Contact Person Responsible for Application Submission

First Name	Stephanie
Last Name	Harrington
Telephone	(401) 462-1818
Fax	
Email Address	stephanie.harrington@bhddh.ri.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State: *Rhode Island*
Grant: *Block Grants for Community Mental health Services*
Project: *Bipartisan Safer Communities Act (BSCA)*
Project Period: *09/30/2023-09/29/2025*
Total Allowable Budget: ***$203,204***

1. The continuum of services that are currently available to respond to a mass shooting event has been thoroughly examined. The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) met with partner public agencies to identify gaps in the crisis response system. The gap that was identified was a highly trained immediate 24/7 response team specializing in trauma.

2. Rhode Island plans to use the BSCA supplemental funds to develop a highly skilled team of responders. The skills will be specific trauma, gun violence, addressing children and families in crisis. Included will be special focus on identifying and referring children and young adults with a serious emotional disturbance.

3. The dispatch of the trauma response team (TRT) will be imbedded in the states already established Rhode Island Medical Reserve Core (RIMRC). The RIMRC has well established relationships with law enforcement, emergency management and the continuum of behavioral health services and has a 24/7 call center. The gap as identified above, is the specialized training to address trauma, chaos, and the crisis in the immediate aftermath of the event.

4. A traumatic event exasperates those individuals with currently existing issues such as serious emotional disturbance, entanglement in the criminal justice system, and those with insecurities such as housing and basic needs. The developed training will contain modules on identification of existing mental illness, emotional disturbances, basic needs and how to link the individuals and families to needed resources.

5. The development of this plan necessitated the coordination of a number of other agencies that provide emergency services. BHDDH met with the Office on Health and Human Services (OHHS) which oversees the state agency providing children's behavioral health services and children's mobile response. The Rhode Island Department of Education and the personnel that are responsible for the Emergency Preparedness within the schools; BHDDH staff responsible for policy, program, fiscal and data components; 988 Planner; and RI RIMRC as mentioned above. All agencies expressed during the meeting that adding a mental health component to the states crisis emergency response plan was needed to fill a gap.

6. A component of the RFP and development of this program will be to include culturally and linguistically tailored messaging, recruitment of volunteers and appropriate supports.

7. Rhode Island will be using the 10% FEP set aside requirement on Seeking Safety trainings to be implemented throughout the state. This will only be used the second-year cycle.

8. 988 Crisis Call Center is meeting the 5% crisis set-aside requirement.

Category	**Total Proposed Cost**
Personnel	$0
Fringe	$0
Travel	$0
Equipment	$0
Supplies	$0
Contractual	$203,204
Total Direct Costs	$203,204
Total Indirect Costs	$0
Total Project Costs	**$**203,204

Personnel **$0**

- No requested funds

Fringe **$0**

- No requested funds

Travel **$0**

- No requested funds

Equipment **$0**

- No requested funds

Supplies **$0**

- No requested funds

Contractual **$203,204**

- Traumatic Response Team: $172,723.40

The specific responsibilities of the TRT will be to receive crisis calls from the community, including police, firefighters, EMT, schools and from BHDDH to dispatch a mobile response team. TRT will develop a cadre of robustly trained volunteers, recruited from professional settings. The volunteers will be properly prepared to function in an emergency crisis developing from a traumatic event. The highly trained volunteers would be dispatched to respond 24/7 to respond to the site of the traumatic event along with first responders. The volunteers will be recruited from Rhode Island schools and behavioral health providers and focus on a multidisciplinary composition. The purpose for the response is to minimize the effects of the traumatic event for the families involved by providing mental health crisis support. The trainings provided will also enhance the skills and knowledge of the behavioral health community by providing specific training on trauma to staffing of community behavioral health organizations.

RIMRC will be responsible for dispatching the TRT, maintaining collaborative relationships with all involved parties, primarily the Department of Education (RIDE), schools and emergency responders and behavioral health organizations including 988 and all other mobile crisis response programs. The TRT will be a subset of the larger RIMRC responders, specifically dispatched to the community resulting from a traumatic event.

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

Required Set Aside/Cap	**Programs Included in Required Set-Asides**	**Total Cost of Set Asides**
10% First Episode Psychosis	Seeking Safety statewide implementation	$20,320.40
5% Crisis	988 Crisis Call Center	$10,160.20

- Seeking Safety Training: $20,320.40 (10% First Episode Psychosis required set-aside)

Seeking Safety is an evidence-based, present-focused counseling model to help people attain safety from trauma. It can be conducted in a group (any size) an/or individual modality. BHDDH is utilizing Seeking Safety as a trauma informed therapy model to enhance other evidence-based models which will enrich clients lives for the better. The target audience for this program are the clinicians for the Healthy Transitions programs, embedded in the CMHCs who provide services to the ESMI population. After an extensive review of available trauma treatment, Seeking Safety was found to be the best fit of the interventions to RI's culture and context as well as evaluation of total cost of implementation, including training and program materials.

- 988 Crisis Call Center (5% Crisis required set-aside)

Horizon Healthcare Partners shall operate a statewide 24/7 clinically staffed hub/crisis call center for 988 that provides crisis intervention capabilities (phone, text, chat, and follow-up) for all Rhode Island populations across the lifespan.

Total Direct Charges: $203,204

Indirect Charges: *$0*

- No requested funds

Total Project Costs: **$**203,204

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
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Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: _____

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

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
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Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
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Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: Rhode Island

Name of Chief Executive Officer (CEO) or Designee: Louis Anthony Cortes

Signature of CEO or Designee[1]: Louis Anthony Cortés

Title: Acting Director BHDDH

Date Signed: 07/24/2023

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Printed: 12/1/2023 2:28 PM - Rhode Island - OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

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STATE OF RHODE ISLAND

OFFICE OF GOVERNOR DANIEL J. MCKEE

June 21, 2023

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

Dear Ms. Pang,

I am writing to notify you that Louis A. Cerbo, Ph.D., is authorized as my designee to sign any required documents related to the Projects for Assistance in Transition from Homelessness (PATH) grant, the Community Mental Health Services and the Substance Use Prevention, Treatment and Recovery Services Block Grants (including the annual Synar report) during his tenure as Interim Director of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.

Sincerely,

Daniel J. McKee
Governor

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
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The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

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

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**

Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

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1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

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

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

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

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

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

State: Rhode Island

Name of Chief Executive Officer (CEO) or Designee: Louis Anthony Cortes

Signature of CEO or Designee[1]: Louis Anthony Cortés

Title: Acting Director BHDDH

Date Signed: 07/24/2023

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Louis Cerbo

Title

Acting Director

Organization

Behavioral Health, Developmental Disabilities and Hospitals

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Form is not needed for RI due to the fact that there is no lobbying activities to disclose.

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

2023

Blueprint to a Comprehensive Behavioral Health System of Care for Adults in Rhode Island

RI DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS

AUGUST, 2023

Table of Contents

Introduction

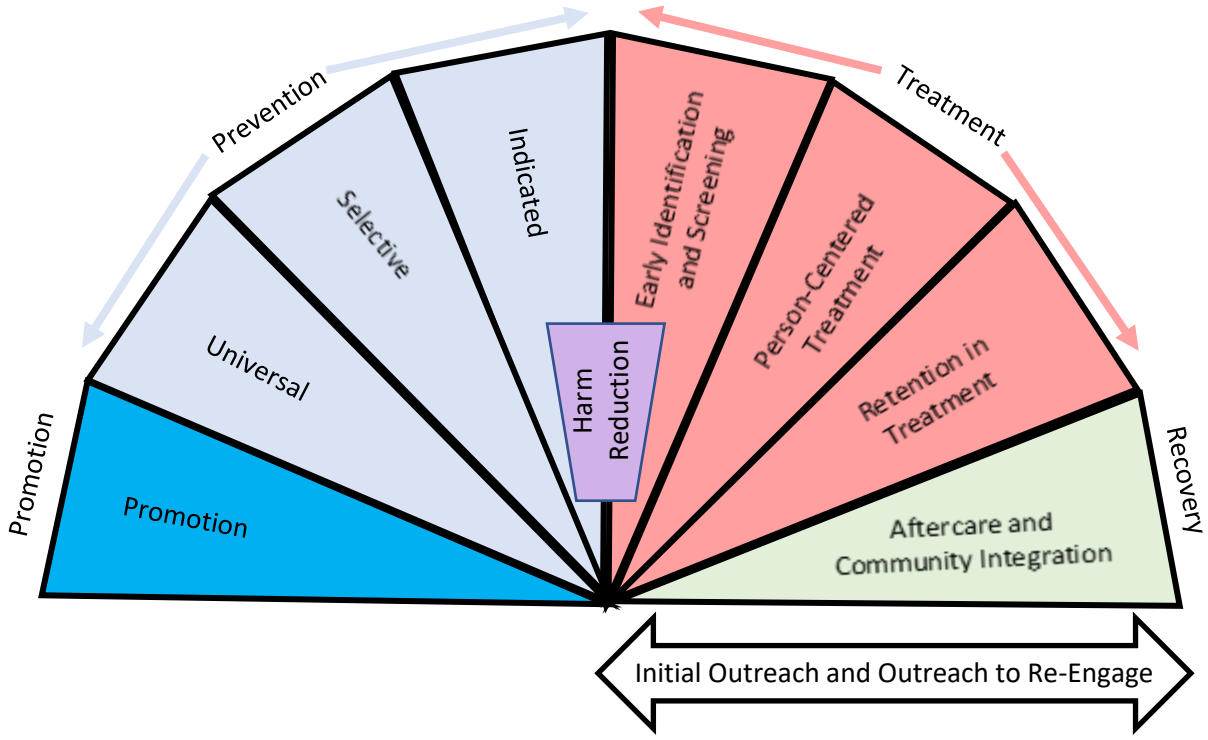
To align with the Governor's 2030 plan and the strategic priorities of the Executive Office of Health and Human Services, Rhode Island needs to remedy funding, access, equity and quality concerns to modernize the behavioral healthcare system and reinvest in the community system of care.

Our vision for a modern Behavioral Healthcare system is that:

Rhode Islanders across the lifespan, will achieve hope and wellness within healthy communities, enabled by a comprehensive, integrated, prevention, treatment, and recovery system of care.

Behavioral Health Continuum

The chart below depicts the behavioral healthcare continuum. When we discuss behavioral healthcare, we are referring to both mental health and substance use services. The continuum begins with behavioral health promotion, moves to the prevention of behavioral health conditions, to treatment and then recovery. Harm reduction is a strategy that helps people stay healthy while they are still considering making changes in their lives to improve their behavioral health. This occurs through engaging directly with people who use drugs to prevent overdose and infectious disease transmission; improve physical, mental, and social wellbeing; and offer low barrier options for accessing health care services, including substance use and mental health disorder treatment. All of the components along the continuum are delivered with an eye toward diversity, equity, inclusion and the social determinants of health.



To operationalize our vision, the following strategies will need to be realized:

1. Prioritize investments in mental health promotion, substance use prevention, screening and early identification as currently practiced in the public health system
2. Replicate the physical health priorities of preventing illness and detecting illness as soon as possible and refer individuals to the appropriate service within the behavioral healthcare continuum in the community
3. Develop communications and partnerships to increase the quality and equity of care for all individuals particularly those who have traditionally been underserved or poorly served due to their race, gender, sexual identity/orientation, culture, language spoken or other characteristics that may characterize them as outside of the mainstream
4. Finance to scale access to crisis response, outpatient and residential treatment services at the time of need
5. Invest in human, financial and technological resources to support the use of evidence-based practices to fidelity to achieve better client outcomes
6. Ensure access to affordable and supportive housing integrated into the community
7. Ensure access to integrated employment and supportive employment services
8. Employ strategies at all Sequential Intercept Points to support justice involved individuals that have behavioral health conditions
9. Support the integration and collaboration of behavioral healthcare with physical healthcare

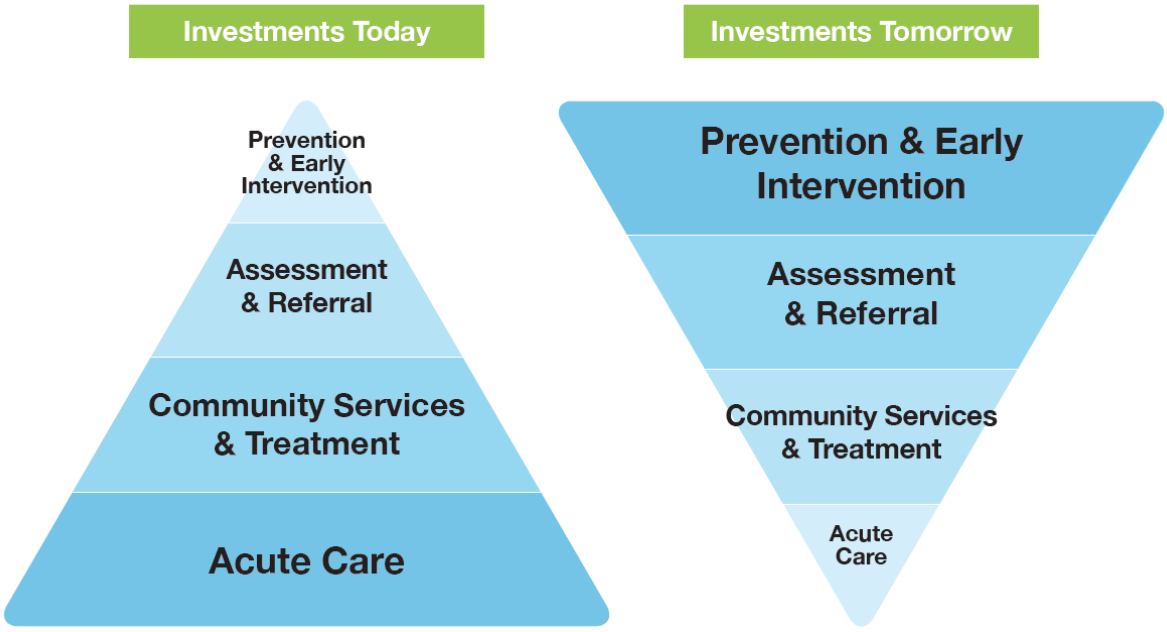
We anticipate that these strategies will result in reductions of:

- Overdose deaths, deaths by suicide, and alcohol related deaths
- Emergency Department (ED) visits for alcohol related complications/overdose
- ED visits for opioid overdose
- Rates of re-hospitalization to inpatient psychiatric settings (forensic and civil)
- Costs of emergency and other expensive deep-end services

In order for these strategies to be successful, transformational change is required, i.e. new frameworks, concepts, and structures that will be implemented at the state and local community levels. The epidemiological service use data and costs all point towards a fundamental rethinking in the way services are planned and funded, the costs of not doing so – morally, socially and economically – are too great.

As the figure below shows, Rhode Island has been too dependent on deep end services to react to the needs of people with complex behavioral health conditions. We need to turn the triangle upside down and be more planful in structuring our system of care.

INVERTING THE TRIANGLE



The behavioral healthcare system in Rhode Island was once the model for all other states indicative of the triangle on the right. Over the past three decades shifts in State budgeting has reduced the foundational infrastructure of the community-based behavioral healthcare system leading to a huge gap in services and a dramatic uptick in expensive institutional settings. Several reports commissioned to assist in establishing a roadmap to address the gaps in the behavioral healthcare system have identified similar conclusions. The 2015 Truven Report on Rhode Island's behavioral healthcare system stated, "Rhode Island has the scaffolding for a high-performance behavioral health system, but the glue that allows this framework to produce high-quality, cost-effective results could be strengthened." The Faulkner 2021 System Review report stated that "Payments for behavioral health services largely rely on a fee for service chassis that does not account for quality or outcomes."

The state of the current system of care has led to a call to action to improve Rhode Island's behavioral healthcare system. State agency partners have conducted resource mapping and analyses of Strengths, Weaknesses, Opportunities and Threats (SWOT) to develop this blueprint. The result reflects the mutually-agreed-upon vision for the adult behavioral healthcare continuum and provides an overview of current changes in process, additional transformation priorities and needs, and assets to be leveraged across State agencies.

Strengths, Weaknesses, Opportunities and Threats (SWOT)

The following tables provide a brief SWOT analysis of the core components of the behavioral healthcare continuum. This analysis served as the critical context for the goals and challenges outlined in the next section. A detailed description of the service continuum is provided in Appendix B.

SWOT Analysis - Prevention

Strengths	Data-driven planning and implementation of programs, positive outcomes
Weaknesses	Traffic violation fines earmarked for prevention are not collected and programs are dependent upon federal grants for funding
Opportunities	Introduce legislation to collect fines per the 1987 Rhode Island Substance Abuse Prevention Act (RISAPA)
Threats	Risk of a federal financial penalty to the RI Mental Health and Substance Abuse Block Grant for lack of state funding 1) to support Maintenance of Effort and 2) tobacco enforcement to maintain Synar Rate of tobacco sales to underage.

SWOT Analysis - Crisis Continuum

Strengths	RI's 988 Lifeline has consistently ranked among the top 3 local answer rates in the country. CCBHC will assist with the build out of mobile crisis statewide.
Weaknesses	BH Link, the state's walk-in crisis triage and stabilization facility, is not serving the anticipated number of individuals in the state due, in part, to its location.
Opportunities	Enabling legislation to collect fee from phone bills to fund the crisis system. Fill in gaps in the crisis system by opening new places for people in crisis to go, like a peer-run respite facility. The State is in process of funding an IT system that will help to coordinate crisis response and referrals.
Threats	Workforce availability and the cost of the system

SWOT Analysis – Mental Health Treatment

Strengths	Moving to the Certified Community Behavioral Health Clinic (CCBHC) model will fill in gaps for crisis services and improve reimbursement rates for outpatient services.
Weaknesses	Mental Health Psychiatric Rehabilitative Residences (MHPRRs) continue to be underfunded and lack pathways to less restrictive housing settings, long term care supports and end of life care.
Opportunities	Improve rates for MHPRRs to build capacity. Use CCBHC to provide the services to ensure individuals with mental health conditions can obtain and maintain housing
Threats	Lack of affordable housing for individuals to move on to if they no longer need MHPRR level of care, Individuals with SPMI/SMI become homeless.

SWOT Analysis - Substance Use Treatment

Strengths	RI has a robust network of providers of medications for Opioid Use Disorder Some outpatient SUD services will be covered by the CCBHC model which will improve reimbursement rates. RI has remained at a flat rate of increases in overdoses while surrounding New England states have increased. RI has strong community participation in the Governor's Overdose Prevention and Intervention Task Force.

Weaknesses	SUD residential facilities continue to be underfunded with low Medicaid rates resulting in closures. There is a lack of “on-demand” detox and residential treatment beds. As housing is the most important social determinant of health, the lack of affordable and supportive housing causes individuals to cycle through expensive treatment services. There are little known evidence-based practices beyond contingency management for those with Stimulant Use Disorder.
Opportunities	An abundance of funding has been invested nationally in combatting the opioid epidemic, including local Attorney General settlements with several of the pharmaceutical companies. A pilot program to implement Contingency Management has begun with the intentions of incorporating into RI’s 1115 waiver for sustainability purposes. A pathway to housing can be created through partnerships with the Department of Housing and RI Housing for individuals in our system to reduce expensive service utilization and reduce trauma. Pilot a “State Bridge Subsidy Program” using a cost avoidance model.
Threats	New and dangerous drugs like fentanyl and xylazine are infecting the RI drug supply, challenging any progress being made in reducing overdose deaths. Individuals, families and communities continue, particularly Latinx to be impacted by overdoses from not only opioids but also stimulants and counterfeit pills.

SWOT Analysis – Recovery Aftercare and Community Integration

Strengths	DBH has built up its cadre of Certified Peer Recovery Specialists and introduced several Peer programs that are being replicated in other states.
Weaknesses	There are challenges to billing for recovery services which creates an overreliance on grant funding. Pay for CPRS is very low and there are CPRS who leave the field shortly after entering it because they aren’t making enough to survive. There is not a pathway from recovery housing into affordable or supportive housing.
Opportunities	An abundance of funding has been invested nationally in combatting the opioid epidemic and recovery in general, so currently the system is fairly well funded. Create State funded Recovery Housing program as well as a bridge subsidy program.
Threats	When grant funding decreases, some programs may be in jeopardy.

Approach to Behavioral Health Planning

As stated in the introduction, there is a planning unit in DBH; also, a data unit and strategy unit exist in Central Management. These groups work collaboratively with other BH units to apply for grants, to develop new programming and make any needed improvements to existing programming. In addition, various planning teams work with EOHHS to implement programs, particularly those involving a significant investment from Medicaid. DBH also consults with the Governor’s Council on Behavioral Health and the Governor’s Overdose Task Force to solicit consumer and other stakeholder feedback on the system of care. In addition to these organized groups, BHDDH funds and engages in planning activities with other advocacy and peer-run organizations including the National Alliance on Mental Illness (NAMI), the Mental Health Association (MHA), Rhode Island Communities for Addiction Recovery

Efforts, Inc. (RICARES) and the trade organization for licensed Behavioral Healthcare Organizations, the Substance Use and Mental Health Leadership Coalition.

On an ongoing basis, DBH utilizes data to identify unmet need and to assess progress in achieving established performance and outcome measures.. In addition to statutorily required data collections and needs assessments, DBH also collects and analyzes data to support special projects and to comply with discretionary and formula grant requirements. DBH and other entities also develop needs assessments for particular populations or geographical areas. Many common goals have been identified in these analyses.

Approach to problem solving, Planning must consider specific sub pops how do we do this? Silos, funding, community engagement

POPULATION	INTERVENTION
Whole Population	Promotion
Well Population	Universal Prevention
At Risk	Selective Prevention
At Risk High	Early Intervention
Mild	Primary Care
Moderate	Primary Care
Severe	Specialty
Severe/Persistent, Complex	High Specialized

BHDDH established a Systems Review (SR) initiative as an avenue to create partnerships between BHDDH and the full network of community providers. The SR meets, in-person, quarterly in each of the 8 catchment areas, facilitated by each CMHC and two representatives from BHDDH. Each SR will evaluate the services, client flow, and gaps within their designated CMHC catchment area. The SR addresses the comprehensive behavioral health system within its catchment area to include planning, prevention, early intervention, treatment, and recovery support efforts. Each SR has a standardized agenda, process, and format for minutes. This allows for the collection of qualitative and quantitative data, identification of best practices, gaps, and feedback from key informants. This information is used to help inform a statewide needs assessment and guide behavioral health planning.

Drafting certification standards and regulations to support DBH initiatives is an integral component of the responsibilities of the Planning Unit. Staff within the Planning Unit also reviews, analyzes, and tracks legislation that potentially impact BHDDH and the populations served by the department; in addition, staff conducts detailed research, prepares concept papers and drafts legislation consistent with departmental priorities.

Behavioral Health Goals

- Focus on prevention and early identification and intervention to support the wellbeing of Rhode Islanders and reduce costs of emergency and other expensive deep-end services
- Increase number of individuals screened for behavioral health in all settings
- Access to treatment on demand
    - Immediate access to crisis response in the community
    - Eliminate wait lists for residential and general outpatient services (GOP)
- Reduce use of high levels of care (forensic and civil)
    - Reduce Emergency Department (ED) visits for alcohol related complications/overdose
    - Reduce ED visits for opioid overdose
    - Reduce rate of re-hospitalization to inpatient psychiatric settings (forensic and civil)
- Increase the quality and equity of care for all individuals particularly those who have traditionally been underserved or poorly served due to their race, gender, sexual identity/orientation, culture, language spoken or other characteristics that may characterize them as outside of the mainstream
- Increase diversion from arrest to reduce the number of individuals in prison due to behavioral health conditions
- Increase integration or collaboration with physical healthcare
- Reduce overdose deaths, deaths by suicide, and alcohol related deaths
- Increase access to affordable and supportive housing integrated in the community to support treatment and recovery
- Increase access to employment and supportive employment to increase income
- Replicate the physical health priorities of preventing illness and detection as soon as possible and create a continuum of services in the community
- Increase the use of EBP's to fidelity to achieve better client outcomes

Challenges to Achieving Our Vision

The State must recognize that behavioral health (mental health and substance use disorders) are on par with physical health conditions and demand the same attention as dictated by the Mental Health Parity Act of 1996 (MHPA). The MHPA requires that large group health plans cannot impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits. Conversely, the State must implement a behavioral health system of care that responds to the social determinants of health. The following list provides examples of the social determinants of health[1], which can influence health equity in positive and negative ways:

- Income and social protection
- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities and the environment
- Early childhood development

[1] Social determinants of health (who.int)

- Social inclusion and non-discrimination
- Structural conflict
- Access to affordable health services of decent quality.

Specific issues that need to be addressed are as follows:

1. **Underfunded behavioral healthcare system** for community evidence-based and innovative behavioral health services and programs. Despite actuarial reviews indicating a need for increases in Medicaid rates, we still have not received general revenue support to increase Medicaid Fee-For Service (FFS) rates to sustain our current behavioral healthcare system in the middle of an opioid overdose crisis and a post-COVID mental health crisis.

2. **Inefficient use of staff resources** around the coordination of payment and investment in behavioral healthcare (BH) services by Medicaid and BHDDH. Lack of inclusion of BHDDH in Managed Care Organization (MCO) procurement and oversight as well as behavioral healthcare system planning—overreliance on consultants which results in duplication of duties and cross-purpose planning. Behavioral healthcare must replicate the health care system and promote prevention an early intervention.

3. **Underpaid workforce** as evidenced by monthly metrics indicating staffing shortages in all BHDDH-licensed behavioral health organizations (BHOs), particularly residential programs and health home teams. This issue predated and was exacerbated by the COVID pandemic.

4. **Treatment Accessibility** for community outpatient behavioral healthcare services; emergency inpatient psychiatric services; American Society of Addiction Medicine (ASAM) levels of care; and facilities that support people discharged from inpatient care for clients with complex medical, substance use, developmental disabilities and behavioral health comorbidities.

5. **Lack of locations/buildings/"landing spots"** for placement of complex clients with chronic behavioral health high-cost treatment needs, to acute detox settings for uninsured and underinsured individuals. This highlights gaps in available residential levels of care for patients. There is also a need for capital investments in state-owned properties.

6. Insufficient **affordable and supportive housing** to allow for movement within the system.

7. **Optimize the use and flow** of the Forensic, Regan and Civil Commitments units of the Eleanor Slater and RI State Psychiatric hospitals to move individuals through the system of care

8. Planning and implementation of **prevention and recovery** programs is disjointed and there is a lack of collaboration across state agencies and community partners.

Call to Action

Given these concerns, BHDDH seeks to target funding on resolving these issues by enacting our vision of a modern sustainable behavioral healthcare system in Rhode Island. We propose developing a comprehensive system of care across the lifespan that addresses the needs of people with all levels of acuity of behavioral health conditions, including those with both mental health and substance use conditions and other co-morbid conditions (homelessness, Intellectual and Developmental Disabilities

(I/DD), trauma, criminal justice involvement, and physical health concerns like traumatic brain injuries (TBI)). To create this modern system, we must have:

- Behavioral Healthcare safety net providers need to become Certified Community Behavioral Health Clinics (CCBHC) within designated geographic areas that adhere to national CCBHC best practice standards. This will allow for:
  - Sustainable financing through a cost-based reimbursement model that ensures parity with funding for the physical health safety net providers
  - Increased capacity and access to services as well as implementation of evidence-based practices to fidelity to improve service quality and result in measurable outcomes
  - Cost-based reimbursement to CCBHCs to pay staff a competitive wage which, in turn will allow them to fully staff the nine required outpatient services[2] and reduce waitlists for these services
  - Designated Collaborating Organizations (DCOs) that support the CCBHCs through cooperative agreements will enhance racial equity and cultural humility as well treatment services for substance use disorders and physical health conditions
  - Collaboration with primary care to ensure that the whole person is treated in an efficient and timely fashion
  - Expansion of services necessary to support sustained recovery including evidence-based supported housing, supported employment and peer support

In addition to CCBHC implementation, the State needs to address prevention, residential programs, housing, and overall governance of programs. Specifically:

- Prioritize primary prevention and early intervention efforts across the lifespan through collection of assessments for prevention coalitions and student assistance services per the RI Substance Abuse Prevention Act and improve collaboration across state agencies and community partners such as Health Equity Zones.
- Conduct rate reviews and increase payment for residential services and other BH services that are not part of CCBHC, and regular inflationary increases built into the rates to cover the cost of providing services so that all programs can staff at necessary levels

[2] (i) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
(ii) Screening, assessment, and diagnosis, including risk assessment.
(iii) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
(iv) Outpatient mental health and substance use services.
(v) Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
(vi) Targeted case management.
(vii) Psychiatric rehabilitation services.
(viii) Peer support and counselor services and family supports.
(ix) Intensive, community-based mental health care for members of the armed forces and veterans.

- Dedicate General Revenue to BHDDH to pay for room and board for residential programs that are unable to secure funds from clients (i.e., through SSI/SSDI)
- Implement a State funded short-term "Bridge Subsidy Program" to allow individuals to access housing opportunities in the community and a pathway to a long-term federal subsidy
- Provide financial support for capital expenses at residential and community-based providers to improve and maintain the physical spaces where service recipients get their services
- Hold MCOs accountable for having adequate network capacity and work with them to develop new landing spots
- Provide supportive services at physical healthcare safety net providers, typically, Federally Qualified Health Centers (FQHCs) that can support people's behavioral health needs as well as their physical health needs, particularly individuals with less severe behavioral health conditions
- Ensure that recovery services are available across the lifespan and in all communities across the state
- Take advantage of fees that are available or written in statute but not implemented such as those for prevention services and 988. Apply for relevant grants.
- Conduct quality monitoring of all behavioral healthcare contracts in the following way by the respective unit: 1) active contract monitoring (contracts) to ensure the vendor is doing what they have agreed to contractually; 2) fidelity monitoring (programs) so that we can document that the vendor is programmatically and clinically meeting best practice standards of care.; 3) outcomes monitoring (data/evaluation) so that we can prove the contract has purpose; and 4) regular system wide review of contracts to determine if there is duplicative overlap that could be redirected to new programming.
- Work with regulators, legal, and the Division of Capital Asset Management & Maintenance (DCAMM) to determine ways to release state properties into the hands of providers so that they can access funding to make the necessary repairs and maintain the properties
- Increase affordable housing stock so that service recipients have a place to step down to if they no longer need a residential level of care
- Work with Eleanor Slater Hospital and the RI State Psychiatric Hospital staff to define the capacity in all areas of the Forensic, Regan and Civil Commitments units of the hospital; who is eligible for those levels of care; and who can safely be discharged into the community
- Improve collaboration across state agencies and community partners such as Lifespan's transitional clinics to coordinate a multitude of support services for our prison re-entry populations to address their physical, behavioral health, housing, and employment needs to reduce recidivism
- Collaborate across state agencies to identify cost avoidance opportunities that can be achieved through the development of a state funded bridge subsidy program
- Train agency staff on housing navigation and retention services to ensure housing stability

Conclusions

This Blueprint is meant to transform the Behavioral Health System, to prioritize proactive investments in prevention, early assessment and community-based treatment over reactive acute institutional care. There is substantial work to be done to improve our system of behavioral healthcare, but the work is not insurmountable. With support from the community of advocates and our parent and sister agencies we are making great strides in modernizing the structure, reimbursement for and accountability of the system of care. The work ahead will require brave and bold leadership from these partners as well as the legislature and other stakeholders, we must commit to this transformation for the benefit of all Rhode Islanders.

The appendices that follow provide a detailed overview of the Department of BHDDH and the behavioral healthcare system.

Appendix A -Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospital's (BHDDH) mission is to ensure equitable access to high-quality, person-centered, and safe services for individuals who have differing intellectual/developmental abilities, mental health/substance use disorders, or are in the care of our state facilities. BHDDH envisions a future where all Rhode Islanders with behavioral health and intellectual/developmental disabilities live and thrive inclusively in supportive communities and have access to quality rehabilitative and psychiatric hospital levels of care when necessary. In collaboration with our community partners, BHDDH is a champion of the people we serve, addressing their needs in a timely, efficient, and effective manner. BHDDH is organized into six program areas: the Division of Developmental Disabilities; the Division of Behavioral Healthcare; Eleanor Slater Hospital and Community Rehabilitative Services and the Rhode Island State Psychiatric Hospital; Central Management; and Hospitals and Services Support. The Research, Data Evaluation and Compliance Unit is responsible for the promotion of data-driven decision-making for the improvement of quality of care, efficiency of service delivery and integrity of behavioral health programing.

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

Most financial matters for the Department are processed through Central Management. These include: procurements, and payments. Fiscal management of grants and contracts remained in the Division of Behavioral Healthcare. With over 300 contracts being managed by DBH, this work is critical to bringing innovation and new dollars into the BH continuum.

Also within Central Management is the Interdepartmental Services Unit which was created to work across Divisions within the Department to provide other administrative support. This Unit includes the following subunits and offices:

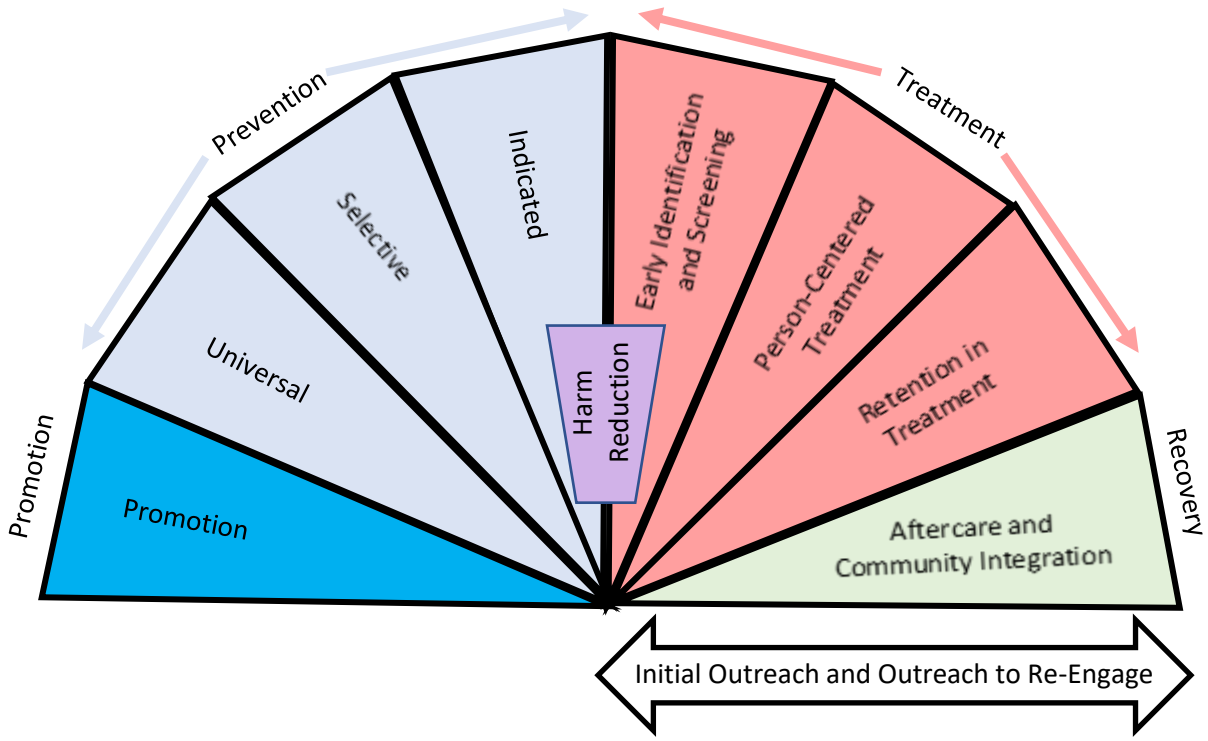
- **Quality Management Unit** that ensures quality and safety for the populations served including the management of the public-facing hotline: (401) 462-2629, where individuals and programs can report suspected incidents of. Staff respond to reported incidents of abuse, neglect, mistreatment and financial exploitation, seven days per week, 365 days per year. Staff offer help to individuals needing assistance accessing benefits and services, and advocates for additional supports as needed.
- **Office of Systems' Design for Vulnerable Populations** that creates systems approaches to ensure vulnerable populations have access to community-based supports.
- **Office of Emergency Management** that supports the functions of the Divisions including but not limited to, internal/external emergency management planning and coordination.
- **Office of Employee Relations and Special Projects** that provides employee relations support to staff by partnering with human resources on personnel and other matters.

One of the other functions of the Quality Management Unit is to license programs that provide services to individuals who are developmentally disabled, cognitively disabled, mentally ill or individuals who

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

Appendix B- Behavioral Health Continuum

The chart below depicts the behavioral healthcare continuum. When we discuss behavioral healthcare, we are referring to both mental health and substance use services. The continuum begins with behavioral health promotion, moves to the prevention of behavioral health conditions, to treatment and then recovery. Harm reduction is a strategy that helps people stay healthy while they are still considering making changes in their lives to improve their behavioral health. We will look at each of these parts of the continuum separately.



PROMOTION

Behavioral health promotion is the process of informing the general public about behavioral health and healthcare whereby messaging is used to help people understand the importance of behavioral health to the whole person and the importance of taking care of oneself to ensure those parts of our lives are in good shape by addressing the eight dimensions of wellness which include mental, physical, social, emotional, financial, spiritual, environmental, and vocational. These dimensions are interdependent and influence each other. When one dimension of our well-being is out of balance, the other dimensions are affected. To keep ourselves in balance we do things like engaging in the community in which we live, finding meaning in life through spirituality, working, seeking educational opportunities and exercising. Also, we must address our basic needs for things like housing and nourishment. DBH currently works with a statewide communications group seated in EOHHS that assists with promotional communications. We do not currently have significant gaps in this part of the continuum.

PREVENTION

As the earlier diagram shows, there are three categories of prevention services in behavioral healthcare: universal that provides education to the whole population; selective that addresses the needs of individuals perceived to be at risk for behavioral health conditions due to life conditions; and selective which is when a person has shown evidence of having a behavioral health condition. The Center for Substance Abuse Prevention identifies 6 Strategy Categories that comprise a comprehensive approach to prevention:

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

Rhode Island has been successful in managing a high quality, data-driven, grant-funded prevention system throughout the state. It focuses primarily on school-age youth but has invested in some programming for adults. As the SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis below shows, the biggest gap in this system is the funding stream.

In 1987, the legislature recognized the need for municipal level, community-based solutions to address the growing problem of substance use. The RI Substance Abuse Prevention Act (RISAPA), established through R.I. Gen. Laws § 16-21.2-1, created a financial mechanism through penalties on speeding violations for the planning and operation of comprehensive programs in every community. Over the years, the financial assistance to support these programs was drastically reduced in various budget cycles and altogether eliminated from the state budget at the end of fiscal year 2014. This resulted in the absorption of these costs by the Substance Abuse Treatment and Prevention Block Grant, discretionary and formula grants and other funding from legal actions, but none from state general revenue. Further, in 2016, the 35 municipal level substance abuse prevention task forces were regionalized to seven prevention coalitions. The intention of the regionalization is to achieve economies

of scale, reduce operating costs, streamline operations and improve outcomes on state identified priorities using evidence based and best practices covering five (5) of six (6) prevention strategies as described above. Funding for prevention services in Rhode Island is now primarily allocated to seven regional coalitions and one provider of Student Assistance Services statewide.

Tobacco Enforcement and the Synar Amendment

Rhode Island has had in place a statute prohibiting the sale or distribution of tobacco products to underage individuals since 1896 (RI General Laws 11-9-13). Prior to an amendment passed by the General Assembly in 1996, the statute was considered to be unenforceable due to the absence of an identified enforcement component. The 1996 amendment established a positive duty to enforce the statute, identified the state and local entities responsible for enforcement actions, and established the parameters within which underage individuals could participate in compliance checks. RIGL 11-9-13.5 *et seq.* identifies BHDDH as the entity responsible for the administration of the statute, specifically as it relates to implementing required checks to determine retailer compliance with the prohibition on the sale or distribution of tobacco products to minors.

Section 1926 of the federal Public Health Act (P.L. 102-321), known as the "Synar Amendment," and subsequent federal reenactments requires each state to have in place and to enforce a statute preventing the sale or distribution of tobacco products to individuals under the age of eighteen as a condition for receipt of federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funding. Currently, states are not required to raise their legal tobacco sales age to twenty-one by statute but are required to enforce a ban on such sales consistent with federal law. Each state is required to conduct an annual statewide random survey of over-the-counter and vending machine retail tobacco license holders and to engage in on-going enforcement efforts to limit the extent to which individuals under the age of 21 have access to tobacco products. Further, states must maintain a violation rate under 20% and document effective enforcement efforts or be *subject to a 10% reduction in their SAPT Block Grant award or other negotiated penalty.*

FDA Tobacco Compliance Inspection Program

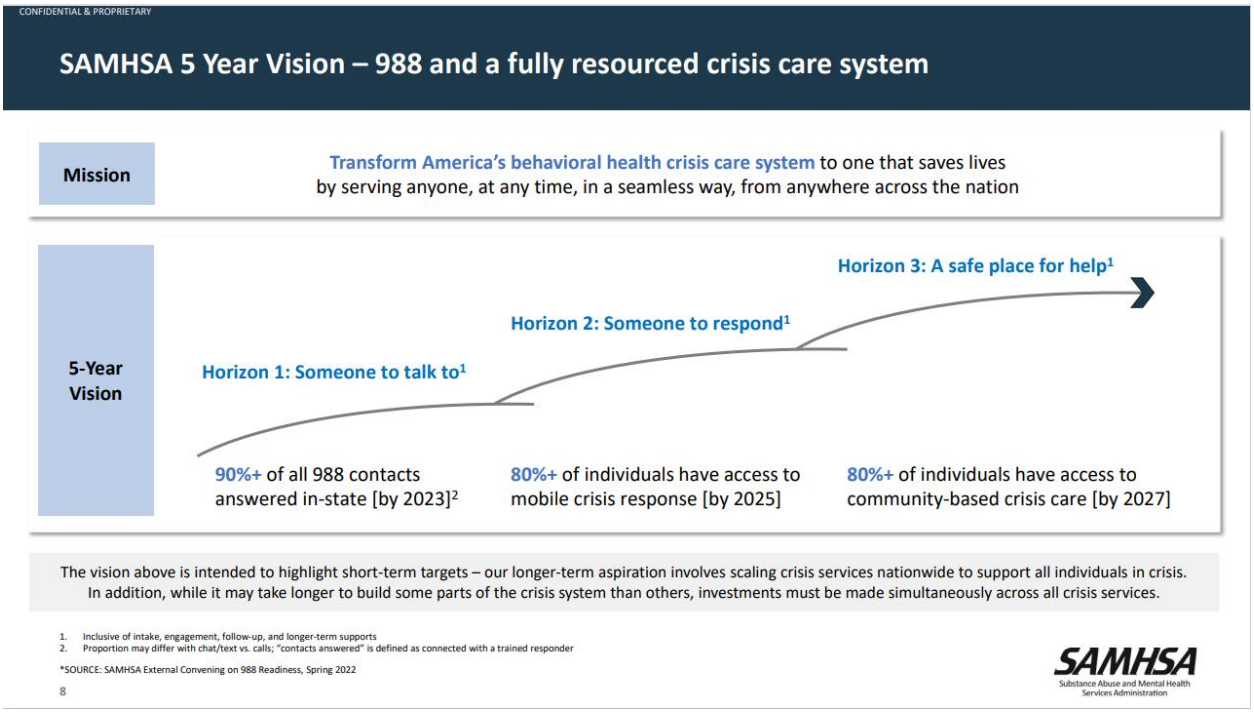
Under the FDA Tobacco Compliance Inspection Program, the FDA conducts inspections of tobacco product retailers to determine retailer compliance with federal laws and regulations related to the sale of tobacco products. The majority of these inspections are performed through contracts between the FDA and the states. BHDDH, as the state agency responsible for coordinating state efforts to prevent the underage sale of tobacco products, holds the FDA contract to enforce certain provisions of the federal 2009 Family Smoking Prevention and Tobacco Control Act ("TCA"). BHDDH works with municipal police departments to provide officers who are commissioned by FDA to conduct undercover buy attempts at licensed retail tobacco outlets utilizing trained minors. Inspections conducted to determine retailer compliance with TCA advertising and labeling restrictions on regulated tobacco products are conducted by BHDDH staff.

Staff within the Division of Behavioral Healthcare Services administer the FDA contract and coordinate state enforcement efforts to prevent the sale of tobacco (including electronic nicotine delivery systems or ENDS products) to underage individuals.

As the SWOT shows, despite the difficulty with funding, the system of care has consistently been data driven and has produced positive outcomes when programs are implemented based on the data. For example, programs directed at reducing marijuana use among youth resulted in decreased youth use in those communities as measured by the semi-annual RI Student Survey.

3 PRONG CRISIS SYSTEM

As the chart below shows, the Substance Abuse and Mental Health Services Administration (SAMHSA) has a 5-year vision for improving crisis response nationwide.



Three Components of the Crisis Continuum

- Someone To Talk To - 988
  A single point of access through the 988 Lifeline

- Someone to Respond – Mobile Crisis Response Teams
  A cadre of mobile crisis response teams dispatched by 988. Teams may have different configurations, specialty areas and geographic locations some of which will be operated by CCBHCs.

- A Safe Place for Help – Walk in/Drop off Triage and Stabilization Center
  23-hour observation and stabilization center (BH Link)

TREATMENT

While many people struggle with both mental health and substance use conditions, there are also many that struggle with just one or the other of these conditions. Therefore, we will discuss them separately as well as discussing co-occurring mental health and substance use conditions. BHDDH-licensed

providers, which are the safety net providers for the public healthcare system for behavioral healthcare, rely very heavily on Medicaid to pay for services. Rhode Island's Executive Office of Health and Human Services (EOHHS) was established in 2007 to strengthen the publicly funded health care system; increase efficiency, transparency and accountability of EOHHS and its departments; promote data-driven and evidence-based strategic decision making, analytical orientation, and EOHHS-wide training in data analysis; improve the customer experience; and integrate budget and finance. Under state law, EOHHS serves as "the principal agency of the executive branch of state government" (R.I.G.L. §42-7.2-2) responsible for managing the departments of: Health (RIDOH); Human Services (DHS); Children, Youth and Families (DCYF); and Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH).

BHDDH provides direct services to nearly 45,000 Rhode Islanders across the lifespan as well as an array of regulatory, protective and health promotion services to our communities. Health and human services benefits represent $4.1 billion spending per year, approximately 40% of the entire state budget. In 2014, the State consolidated behavioral health Medicaid funding under the EOHHS, therefore, the state has requested that BHDDH and EOHHS be co-designated as the State Single Agency, per the provisions established in 42 U.S.C § 300x30(a), solely for the purposes of calculating the Substance Use Prevention and Treatment Block Grant (SABG) maintenance of effort (MOE). Specifically, the designees, BHDDH and OHHS, are to be jointly designated as administering agencies for federal aid purposes; BHDDH remains the substance use authority with sole responsibility for the activities outlined in the pertinent federal substance abuse laws and regulations, including 42 U.S.C § 300x-21 et seq. The General Assembly created this language for the 2017 legislative session which became State of Rhode Island law § 40.1-1-13. Powers and duties of the office pertaining to Behavioral Healthcare, Developmental Disabilities, and Hospitals.

Mental Health Treatment

BHDDH's mental health treatment continuum has levels of treatment that are consistent with an individual's level of need or acuity. The individuals served by BHDDH-licensed facilities are those with any mental health condition, Serious Mental Illness (SMI) and Serious and Persistent Mental Illness (SPMI). Children or youth under the age of 21 who have mental illness may be diagnosed with a serious emotional disturbance (SED), they are also served in our system of care as well as receiving services funded through the Department of Children, Youth and Families (DCYF). The levels of treatment available to adults include crisis stabilization, residential services, supportive housing services, partial hospital and intensive outpatient programs, Assertive Community Treatment, Integrated Health Homes and other community-based treatment. Hospitalizations and inpatient services of care are also accessed by some of these individuals, but these services are overseen by the Department of Health. Individuals with SMI and SPMI that require a nursing home level of care will be assessed by the Preadmission Screening and Residential Review (PASRR) program for their behavioral health needs. We will discuss the services BHDDH oversees below.

Community-Based Mental Health Treatment

Community-based services have been provided by BHDDH-licensed Community Mental Health Centers since the deinstitutionalization of mental hospitals. These CMHCs are regulated by BHDDH although they receive their funding from managed care organizations overseen by Medicaid which is with the Executive Office of health and Human Services. BHDDH, DCYF and EOHHS are in the process of transforming our system of care by implementing the Certified Community Behavioral Health Clinic (CCBHC) model. This model ensures access to a sustainably financed model of integrated, evidence-based substance use disorder and mental health services, including 24/7 crisis response and some forms

of medication-assisted treatment (MAT). These specially designated clinics serve anyone who walks through the door, regardless of their age, diagnosis and insurance status.

Also, the CCBHC functions as a fixed point of responsibility for ensuring a quality community tenure of persons with serious conditions, and as the "least restrictive setting" - the CCBHC collectively would assume function as the organizational entity for portal of entry and gatekeeping functions on a range of "deep-end" services. Currently most service dollars go to support high levels of inpatient care, criminal justice beds, or nursing home beds.

CCBHCs are required to provide nine core services, which they can provide directly or via formal relationships with Designated Collaborating Organizations (DCOs):

1. Crisis Services
2. Treatment Planning
3. Screening, Assessment, Diagnosis & Risk Assessment
4. Outpatient Mental Health & Substance Use Services
5. Targeted Case Management
6. Outpatient Primary Care Screening and Monitoring
7. Community-Based Mental Health Care for Veterans
8. Peer, Family Support & Counselor Services
9. Psychiatric Rehabilitation Services

https://www.samhsa.gov/certified-community-behavioral-health-clinics

At the time of this writing, BHDDH is reviewing CCBHC applications for eight catchment areas with an anticipated start date of February 2024. Needs assessment data will help to inform if there is a need for more than one CCBHC per catchment area. CCBHCs will have the ability to provide all nine required CCBHC services throughout the entire catchment area that the vendor is applying to serve. CCBHCs are expected to enter into partnerships with Designated Collaborating Organizations (DCOs) sufficient to meet the behavioral prevention, treatment, and outreach needs in their catchment area consistent with the cultural composition of the area. Other collaborative arrangements will also be necessary, including coordination with the 988 call center, schools and other stakeholders.

RI has selected the Perspective Payment System (PPS-2) rate structure which in addition to the monthly tiered, site-specific rates, has a required structure of outlier payments and quality bonus payments. The PPS-2 rate structure will include four population rate categories:

1. High Acuity Adult
2. High Acuity Children and Youth
3. High Acuity Substance Use Disorder
4. General Population

Metrics

- Reduced emergency room visits among those with severe mental illness
- Reduced psychiatric inpatient readmissions among those with severe mental illness

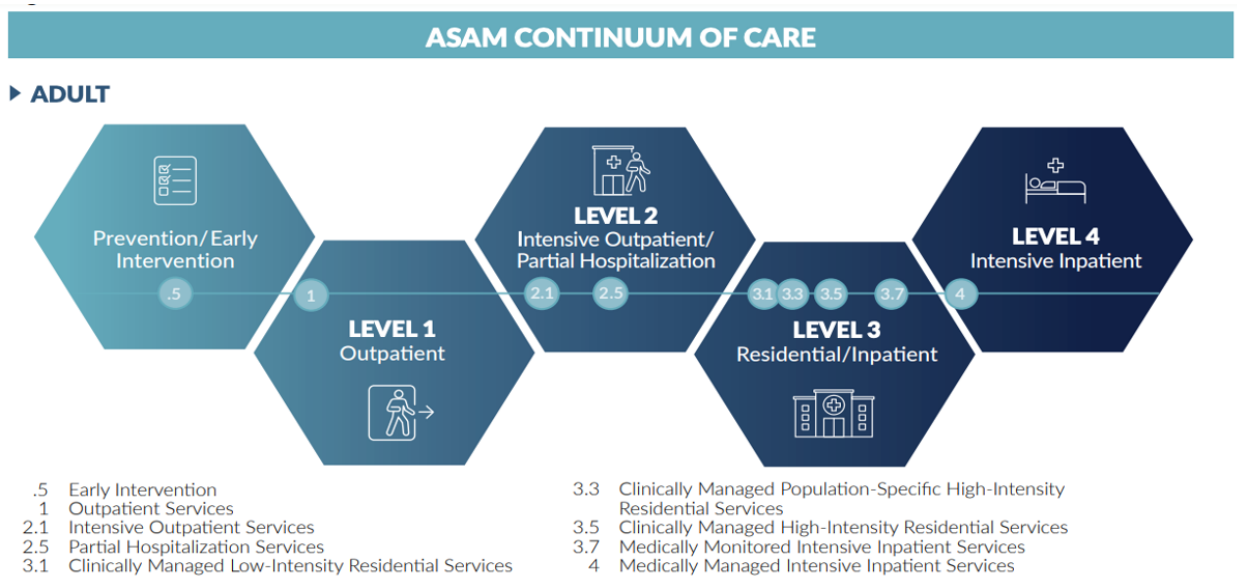
Mental Health Psychiatric Rehabilitative Residences

BHDDH licenses several levels of Mental Health Psychiatric Rehabilitative Residences (MHPRRs) ranging from supported apartments that have staff available to residents, fully staffed MHPRRs, specialized

MHPRRs for higher acuity individuals or those with co-occurring mental health and substance use conditions and the newest enhanced MHPRR that serves high acuity individuals with co-morbid health conditions.

Substance Use Treatment

The American Society of Addiction Medicine (ASAM) establishes criteria to assess the appropriate level of care for addressing a person's substance use and mental health at the time of assessment. The ASAM levels of care include early intervention, outpatient treatment, intensive outpatient/partial hospitalization, residential care and inpatient treatment. While the state, like the nation, is in the middle of an opioid epidemic, RI also has a high incidence of alcohol misuse and must also address the misuse of stimulants and other drugs including marijuana which recently became legal to use recreationally.



Screening and Early Identification and Referral

- **ASAM Level 0.5** Early Intervention. Early intervention can consist of assessment and education for people at risk of developing a substance use disorder, or programs like DUI classes for people arrested for driving under the influence. The goal of .5 services is to intervene before a person develops a substance use disorder.

Examples of screening include Screening, Brief Intervention and Referral to Treatment (SBIRT) in primary care practices and health centers using a variety of validated screening tools. Student Assistance Counselors may also conduct screening in school settings to make referrals to treatment.

BHDDH is working to implement use of a standardized Global Behavioral Health Screener (GloBHS) in other non-medical and health settings. Having a standardized tool to determine level of care (LOC) used throughout the state can provide a rich data set of the behavioral services needed by individuals encountered through street outreach, public housing, transitioning from prison, and those receiving a variety of non-clinical supportive services.

GloBHS is a brief screening tool (meant for non-clinicians to be able to use in about ten to fifteen minutes) that results in a preliminary substance use disorder placement as well as alerting the screener to other mental and physical health needs for follow up care. The LOC that is recommended by the tool should be verified with a full clinical assessment at intake with a clinical professional. To be clear, the only level of care placement the GloBHS recommends is for SUD services in that the tool will provide a recommendation for a modality such as residential placement, but not the specific ASAM level of residential (e.g., 3.1). A full clinical assessment will be required to make that determination. The tool can also determine if an individual qualifies for a referral to Coordinated Entry services based upon the federal definition of homelessness.

Screeners will use the GloBHS to facilitate the referral process, once it is established that:

- there are no emergency issues
- no BH Link walk in appointment is recommended/needed
- no Home/Community visit by BH Link staff is recommended/needed

no home-based assessment by EMS/Police is recommended/needed

Outpatient Services

There are three levels of outpatient services identified by ASAM that are provided by BHDDH-licensed providers as well as some private practitioners that are not licensed by BHDDH. These levels are as follows:

- **ASAM Level 1** Outpatient Treatment consists of treatment for substance use that is less than 9 hours a week. Level 1 is appropriate for people with less severe disorders, or as a step-down from more intensive services.
- **ASAM Level 2.1** Intensive Outpatient Services (IOP) consisting of at least 9 and no more than 20 hours per week of treatment. These programs typically offer medical care 24 hours a day by phone or within 72 hours in person.
- **ASAM Level 2.5** Partial Hospitalization Program (PHP), which is at least 20 hours a week but is less than 24-hour care. This level of care provides structure, and daily oversight for people who need daily monitoring, but not 24/7 care.

In addition to the previous outpatient levels of care BHDDH licenses and works closely with our federal DEA and SAMSHA partners to ensure compliance and to provide local oversite via the State Opioid Treatment Authority position who is a designee by BHDDH to monitor all opioid treatment programs (OTP). The OTPs provide medication assisted therapy for opioids and polysubstance use with medications such as methadone, buprenorphine and naltrexone. Additionally, OTPs offer support services such as HIV screening, mental health counseling and some medical services. Service recipients may also access OTP health home services to address physical health and other social determinants of health. BHDDH is working to incorporate as many of these outpatient services as possible into our new CCBHC model.

Residential Services

ASAM identifies and BHDDH-licensed providers who offer three levels of residential services for individuals with an alcohol or a substance use disorder. They are as follows:

- **ASAM Level 3.1** Clinically Managed Low-Intensity Residential Treatment. Residential services at this level consist of a setting where people reside and receive counseling services. However, treatment is only required to be 5 hours per week, which helps people with such topics as relapse management and discharge planning.
- **ASAM Level 3.3** Clinically Managed High-Intensity and Population-Specific Services. Level 3 encompasses residential services that are described as co-occurring capable, co-occurring enhanced, and complexity capable services, which are staffed by designated addiction treatment, mental health, and general medical personnel who provide a range of services in a 24-hour treatment setting.
- **ASAM Level 3.5** Clinically Managed High-Intensity Residential Services for adults, this level of care provides 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Patients in this level are able to tolerate and use full active milieu or therapeutic communities.

The Medicaid fee for service rates for these services or have been historically a big challenge for providers. Because there is a need for room and board at a residential facility it requires providers to find other sources of funding for the room and board. They may seek some reimbursement from service recipients, that many of them do not have the funds to be able to pay for it. Medicaid is unable to pay for room and board and unlike some other states, Rhode Island does not invest in any general revenue to pay for room and board. This is a gap in our continuum that will be addressed later in the strategic plan.

Inpatient Services

ASAM identifies two levels of inpatient services which are as follows:

- **ASAM Level 3.7** Medically Monitored High Intensity Inpatient Treatment. These services are for people who need intensive medical or psychological monitoring in a 24-hour setting but do not need daily physician interaction.
- **ASAM Level 4** Medically Managed Inpatient Services offers 24-hour nursing care and daily physician visits. People in this level of care need daily physician monitoring, along with 24-hour oversight and are usually hospitalized.

BHDDH-licensed providers offer level 3.7 services. Level 4 services are provided in hospitals licensed by the Rhode Island Department of Health. BHDDH has struggled to ensure that there is enough capacity within level 3.7. Once again this is a concern related to rates coming from Medicaid fee for service.

RECOVERY AFTERCARE AND COMMUNITY INTEGRATION

SAMHSA's working definition of recovery defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Hope, the belief that these challenges and conditions can be overcome, is the foundation of recovery. A person's recovery is built on his or her strengths, talents, coping abilities, resources, and inherent values. It is holistic, addresses the whole person and their community, and is supported by peers, friends, and family members.

The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. Recovery is characterized by continual growth and improvement in one's health and wellness and managing setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery.

The Four Major Dimensions of Recovery:

- **Health**: overcoming or managing one's disease(s) or symptoms, and making informed, healthy choices that support physical and emotional well-being
- **Home**: having a stable and safe place to live
- **Purpose**: conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
- **Community**: having relationships and social networks that provide support, friendship, love, and hope

https://www.samhsa.gov/find-help/recovery

Peer Recovery Specialists

Rhode Island was the first state to institute a joint certification for Peer Recovery Specialists (PRS) that encompasses addressing both mental health and substance use. PRS are individuals with lived experience of a behavioral health condition, this could be experience with their own condition or experience supporting a loved one with these conditions. PRS work in a variety of settings including on treatment teams, as crisis responders, as individuals conducting outreach and in recovery community centers.

Agencies that wish to receive Medicaid reimbursement for services provided by Certified Peer Recovery Specialists must demonstrate their compliance with minimum standards set by Medicaid and BHDDH through submission of an application to BHDDH to become a certified provider.

Recovery Community Centers

Recovery Community Centers (RCC) are peer-operated centers that serve as local resource hubs of community-based recovery support. RCCs help people build recovery capital at the community level by providing mutual aid support, resource navigation, advocacy training, social activities, employment and education support, and other community-based services. They help facilitate supportive relationships among people in recovery, as well as community and family members. BHDDH funds 4 agencies that operate 6 RCCs across the state. A list of locations may be found at https://bhddh.ri.gov/substance-useaddiction/recovery-services.

Recovery Housing

Recovery residences offer a substance free living environment for individuals recovering from substance use disorders. Recovery residences function as a supportive dwelling and are not halfway houses or programs that are required to be licensed by any state agency, in that they do not provide rehabilitation, treatment, supervision or dispensing or management of medications. While Recovery residences are not

required to be licensed, RI General Law § 40.1-1-13 requires that all referrals made from state agencies or state-funded facilities must be to certified residences that meet national standards outlined by the National Alliance of Recovery Residence (NARR).

NARR's certification standards are organized across 4 domain areas: Administrative Operations, Physical Environment, Recovery Support and Good Neighbor. Standards are tailored to each of NARR's 4 levels of support that are distinguished by the level of services and support offered at a residence.

DBH supports over 40 recovery houses in different parts of the state, with over 500 certified level 2 beds. Some focus on special populations, such as including women and Veterans. They play an instrumental role in helping people recover in a safe environment. More information about state funded recovery houses can be found here https://ricares.org/certified-recovery-houses/

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

Paid media campaigns have focused on how access programs such as 988 Lifeline, 942-STOP, BH Link, Substance Exposed Newborn (SEN) programs, and how to find treatment and recovery within our community. Published calendar events include how and where to visit a mobile van that can provide SUD/MOUD treatment services. RI Outreach (RIO) program supports crisis work at hotspots in the community. Educational seminars, Narcan distribution, and prevention workshops increase community awareness. BHDDH regularly meets with various state agencies (including the Department of Health (DOH), Department of Children, Youth and Families (DCYF), and Department of Corrections (DOC)) to address the overdose crisis, re-entry populations, and transitional and treatment issues. We also remain committed to offering information on harm reduction, HIV and TB testing, and mobile van services.

The RI SUD system offers a multitude of accessibility options: Opioid Treatment Programs (OTP), 988 Lifeline, BH Link 24/7 call line, Buprenorphine call line, recovery housing call line (942-STOP), and crisis stabilization units. Most of which primarily rely on a braided funding arrangement, thus maximizing opportunities. RI also offers every ASAM level of residential care included a new program being piloted called “Safe Landings”. The Safe Landings program is a 30-day residential peer respite program which serves individuals who may have overdosed multiple times but are not yet committed to engaging in a residential or MOUD level of care.

The state’s State Epidemiological and Outcomes Workgroup (SEOW) actively collects data as part of its primary prevention needs assessment process. Data points include the consequences of substance using behaviors, substance using behaviors, and intervening variables such as risk and protective factors. The state also collects needs assessment data related to the analysis of primary prevention needs for children, youth, adults, older adults, cultural/ethnic minorities, and sexual/gender minorities. The states use data from The National Survey on Drug Use and Health (NSDUH), Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavioral Surveillance System (YRBSS), and state developed survey instruments in its primary prevention needs assessment. The state takes a comprehensive approach to prioritizing substance use prevention goals and objectives, which includes an internal planning team as well as engagement from stakeholders and partners. The state requires coalitions to perform a Needs Assessment every three years which uses such data to determine a population’s level need, impact of consequences, consumption patterns, and risk/protective factors to advance health equity. The Rhode Island Certification Board (RICB) has three certifications for the substance use primary prevention workforce. The Regional Prevention Task Force (RPTF) coalitions plan and develop health fairs, media campaigns, brochures, resource directories, and Public Service Announcements. RPTF coalitions fund evidence-based classrooms, small group sessions, parenting/family classes, and education programs to use for the youth within their communities. RPTF coalitions provide constructive and healthy activities that exclude alcohol, tobacco, and other drug use. Rhode Island Student Assistance Services (RISAS) is the primary provider for student services. Student Assistance Programs (SAPs) focus on behavior and performance at school, using a process to screen students for alcohol, and other drug problems. The counselor provides early identification, comprehensive assessment, intervention, and referral (if necessary), to adolescents experiencing high-risk behaviors. The counselor also acts as a liaison between the school and school personnel, parents, and a variety of community agencies. This model enables a school to carry out its function of educating students more effectively and efficiently. Our SAP provides the PROJECT SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) Prevention Education Series.

The state utilizes a system of care approach to support the recovery and resilience of children and youth with SUD. The state has a plan to work with other child and youth serving agencies to address child welfare, health care, juvenile justice, and education. Training is provided regarding substance

misuse prevention, SUD treatment, and recovery services for children and adolescents and their families. There is also a state plan for transitioning children and youth who are already receiving services to the adult SUD system. Healthy Transitions provides wrap-around services which include a substance use specialist. The Seven Challenges program, a counseling program addressing SUD for adolescents/adults, has been implemented throughout the state.

RI provides a full continuum of services: screening, education, brief intervention, assessment, detox, outpatient, intensive outpatient, inpatient, and aftercare recovery support. Block grant sub-recipient SUD agencies maintain CARF and/or The Joint Commission accreditation. The state makes prenatal care available to PWWDC receiving services, either directly or through an arrangement with another entity. Preference is given to pregnant women for admission to treatment facilities and services are made available in the interim. All contracts include a requirement to monitor compliance for PWWDC, which provides the state with recourse should an agency be found in need of corrective action. Multiple state agencies provide Narcan, fentanyl test strips, wound care, and harm reduction to PWID. Peer recovery supports are also provided to PWID to maintain contact and support and increase access to SUD/MOUD treatment such as engagement in OTPs, outpatient, and inpatient services. OTPs and residential facilities test for TB and a referral is made to a medical provider for treatment upon a positive test result. HIV is screened for SUD/MOUD agencies screen for HIV, and referrals to a medical professional for further testing and treatment is provided as applicable. SUD providers utilize a trauma-informed approach to care with respect to training, assessment tools, and treatment interventions. The Seeking Safety program is trained and implemented in such programs.

The state SMHA and SSA engage in various activities to coordinate services across SUD and the criminal justice system. A crisis system engages people in SUD care and pathways to diversion as an alternative to law enforcement and the criminal justice. The state addresses barriers to recovery for people with SUD involved in the criminal justice system, such as health insurance, SSI/SSDI enrollment, housing, and employment challenges. The state supports law enforcement's ability to respond to people experiencing SUD along with partnering with agencies to improve SUD screening and assessment and standards of care for the incarcerated. The RI District Court Diversion Program provides assessment, treatment recommendations, and consultations for people with SUD, and clinicians provide treatment status updates to the Court. The state supports coordination across community-based care upon reentry into the community, including increasing community capacity to provide SUD/MOUD services. RI has embedded OTPs within the DOC. The Center for Health & Justice Transformation (CHJT) employs a discharge planner who refers people to programs while still incarcerated and develops safe release plans regarding SUD and/or MOUD services. CHJT has a program Lifespan Transition Clinic (LTC) which serves the formerly incarcerated by connecting them to a Community Health Worker (CWH) and/or SUD/MOUD services. There is a Crisis Intervention Training (CIT) program that has certified EMS, fire, police, and providers which has also increased access to treatment and reduced total arrests.

The state supports recovery through training and education on recovery principles, peer accreditation and certification, block grant funding for recovery support services, and the involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the SUD system. Recovery support services for SUD are provided in multiple agencies, including one-on-one peer support, peer-to-peer recovery support groups, recovery education groups, wellness groups, and social hours.

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

Paid media campaigns have focused on how to access programs such as 988 Lifeline and BH Link, and how to find treatment and recovery within our community. RI Outreach (RIO) program supports mental health mobile crisis work at hotspots in the community. BHDDH regularly meets with various state agencies (including the Department of Health (DOH), Department of Children, Youth and Families (DCYF), and Department of Corrections (DOC)) to address behavioral health treatment issues, such as transitional treatment for re-entry populations. We have increased outreach efforts to engage adults with serious mental illness (SMI) and the unhoused to connect them with treatment. We have also increased funding for coordinated specialty care to reach more transitional-aged youth.

The RI behavioral health system offers a multitude of accessibility options: 988 Lifeline, BH Link 24/7 call line, mobile crisis van, Assertive Community Treatment (ACT), Integrated Health Home (IHH), Healthy Transitions (HT), and crisis stabilization units (CSU). Most of which primarily rely on a braided funding arrangement, thus maximizing opportunities. The above hotlines predominantly serve adults with SMI and children with serious emotional disturbance (SED). The state has implemented children's mobile response, targeting children with SED. This program serves as hospital diversion and helps to bridges the gap for children with SED until home services are available to them. Adults with SMI and children with SED that receive services at a Community Mental Health Clinic (CMHC) have access to therapy from a clinician on the ACT, IHH, or HT team to which they are assigned.

There are seven coordinated specialty care programs for those with early serious mental illness (ESMI) and/or first episode psychosis (FEP) which bill both Medicaid and private insurances. The HT program provides coordinated special care for youth and young adults who have, or are at risk of having, SMI, SED, or FEP. A team approach provides individuals with wrap-around services to help them meet their personal goals for improving their mental health and successfully transitioning to adulthood. We increase programs' access to services and improve client outcomes for those with FEP, ESMI, SMI, and/or SED through outreach efforts with our community partners, such as schools, community agencies, parent groups, and hospitals.

IHH is built upon the evidence-based practices of the patient centered medical home (PCMH) model. IHH coordinates care and builds linkages with and among behavioral health, primary care, and other community and social support providers. Members receive assistance with accessing medical, social, educational, vocational, substance, and other support services, as necessary, to meet basic human needs. IHH clients also receive medication management when needed. ACT is a more comprehensive set of services designed to meet all of a member's needs in a community setting. A multidisciplinary team provides the individual with mental health services, care coordination, peer support, pharmacology, substance use counseling, vocational training, and care management. The ACT team is mobile and delivers integrated clinical treatment, rehabilitation, and other supportive services in the community. ACT teams also assist with medication management based on a client's needs. ACT clients are high-acuity and generally a higher risk for hospitalization and homelessness due to persistent difficulties maintaining daily living activities.

988 Lifeline offers 24/7 call, text, and chat access to people experiencing suicidal and mental health crisis. The BH Link program supports individuals in a crisis for behavioral health issues through telephone hotlines, mobile outreach, and a facility that links people to treatment in the community and provides a short-term alternative to emergency department triage. CSUs are hospital diversion and step-down programs for people experiencing a psychiatric crisis. CSU services include assessment, observation, crisis intervention, and ongoing treatment. Mental health psychiatric rehabilitative

residences (MHPRR) programs provide increased structure for individuals whose chronic mental illness prohibits living in a less restrictive setting in the community.

The state of RI follows that person centered planning (PCP) strives to place the individual at the center of decision-making. PCP is based on the values of human rights, interdependence, choice, and social inclusion, and can be tailored to enable people to direct their own services and supports. The PCP could include friends, family, community connections, and other non-professionals as a support. Behavioral health providers utilize a trauma-informed approach to care, with respect to training, assessment tools, and treatment interventions. The Seeking Safety program is trained and implemented in such programs.

The state supports recovery through training and education on recovery principles, peer accreditation and certification, block grant funding for recovery support services, and the involvement of persons in recovery and other social supports (including peers and family members) in the planning, implementation, or evaluation of the impact of the behavioral health system. RI Certification Board (RICB) has created the Peer Recovery Specialist (PRS) and Certified Community Health Worker (CCHW) certifications. Multiple agencies provide recovery support services for adults with SM. Services include one-on-one peer support, peer-to-peer recovery support groups, recovery education groups, wellness groups, and social hours. The Providence Center (TPC) has a teen recovery center for after school hours. Seven Challenges and other agencies provide support to children at the training school.

Rhode Island Student Assistance Services (RISAS) is the primary provider for student services. Student Assistance Programs (SAPs) focus on behavior and performance at school, using a process to screen students for alcohol, and other drug problems. The counselor provides early identification, comprehensive assessment, intervention, and referral (if necessary), to adolescents experiencing high-risk behaviors. The counselor also acts as a liaison between the school and school personnel, parents, and a variety of community agencies. This model enables a school to carry out its function of educating students more effectively and efficiently.

The state SMHA and SSA engage in various activities to coordinate services across MH and the criminal justice system. A crisis system engages people in MH care and pathways to diversion as an alternative to law enforcement and the criminal justice system. The state addresses barriers such as health insurance, SSI/SSDI enrollment, housing, and employment challenges. The Co-Response outreach program consists of CMHC clinicians working directly with law enforcement officers that provide field-based outreach services in addition to diversion focused interventions. The RI District Court Diversion Program provides assessment, treatment recommendations, and consultations for people with behavioral health issues, and clinicians provide treatment status updates to the Court; the goal is to identify persons appearing before the District Court with behavioral health issues and divert them from the criminal justice system by connecting them with the appropriate level of care to safely return to a community setting. The Center for Health & Justice Transformation (CHJT) employs a discharge planner who refers people to programs while still incarcerated and develops safe release plans. CHJT offers the Lifespan Transition Clinic which connects the formerly incarcerated to a Community Health Worker and/or behavioral health services. The Crisis Intervention Training program that has certified EMS, fire, police, and providers has also increased access to treatment and reduced total arrests.

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

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Footnotes:

The “Blueprint to a Comprehensive Behavioral Health System of Care for Adults in Rhode Island” identified the unmet needs and critical gaps in Rhode Island’s current system and then discussed the state’s plans to address them. The Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis focused on prevention, crisis continuum, mental health treatment, substance use treatment, and recovery aftercare and community integration.

Regarding the crisis continuum, BH Link (the state’s walk-in crisis triage and stabilization facility), is serving fewer individuals in the state than originally anticipated, presumably, due to its location and the impact of COVID -19 and the impact on RI’s nursing workforce. Certified Community Behavioral Health Clinic (CCBHC) will provide the opportunity to assist with mobile crises statewide, as well RI’s Mobile Van focusing on MOUD needs. Rhode Island’s 988 Lifeline, a national network that provides emotional support to people in suicidal crisis or emotional distress, has ranked among the top 3 local answer rates in the country. The state is in the process of funding an IT system that will help to coordinate all crisis response and referrals, in addition to providing new locations where people in crisis can physically go to.

Substance Use Disorder (SUD) residential facilities continue to be underfunded. Low Medicaid reimbursement rates have led to the closure of one of our women’s SUD residential facilities. There is a lack of “on demand” detox and residential treatment beds. The state has addressed this issue in two ways; the first attempt has been to utilize State Abatement dollars to procure start-up funds to encourage SUD residential expansion. The second way the state is addressing the issue related to low rates is through a commission formed to review all reimbursable rates related to parity with budget recommendations made to the Governor’s office for budget considerations.

For sustainability purposes, Rhode Island is requesting a Contingency Management pilot program to be held at each of RI’s Opioid Treatment Programs (OTP’s) as part of RI’s 1115 waiver application. We are also looking at a pathway to improved housing through our partnerships with the Department of Housing and RI Housing, in addition to accessing the RISEN grant. A grant that will target homeless or imminently homeless individuals with SUD and/or MH issues for assessment and referral to services. There is also an opportunity to pilot a “State Bridge Subsidy Program” using a cost avoidance model. Table 1 Priority Areas and Annual Performance Indicator #3 shows the targets and outcomes for this population that are in supportive housing.

The analysis of recovery aftercare and community integration identified challenges to billing for recovery services, which fosters an overreliance on grant funding. Certified Peer Recovery Specialist (CPRS) retention is very low, which is likely attributable to unlivable wages. There is not a clear pathway from recovery housing into affordable or supportive housing. Funding has been invested nationally in combatting the opioid epidemic and recovery in general, however, when grant funding decreases program sustainability may be in jeopardy.

According to 2020 N-SSATS State Profile, RI has less hospital bed capacity for individuals versus residential facilities. There are less day treatment programs and partial hospitalization level of care versus the other outpatient levels of care. The data showed only two detoxification non-hospital residential facilities. Hospitals have begun to expand units making services such as the 24/7 buprenorphine hotline more accessible to individuals. MAT programs are implementing IOP programs to provide more supports to the clients. MAT programs provide all three FDA approved medications to assist in treatment. Part of the TEVA settlement negotiated by the state included free buprenorphine for

individual who are uninsured, underinsured, or undocumented. Faith based projects such as RI's "Imani" programs offering a Yale recovery community based curriculum held in underserved minority based churches in several parts of the state. Mobile crisis units go to the churches and offer a variety of services, including but limited to MOUD and harm reduction materials. Mobile emergency services have expanded to meet people where they are to assist with connecting clients to any needed services.

Data from 2020 N-SSATS State Profile showed that there were still several agencies that were not able to offer recovery support services, vocational training, or educational support. These positions have been incorporated into the new CCBHC's team composition of programs. There have been trainings provided to educate the staff on methods to provide increased resources to the clients. These positions will be part of CCBHC.

According to 2022 State Epidemiological Profile and SEOW, RI has the highest rate of unmet treatment needs for young adult drug use disorder in the region along with high school student suicide attempts. RI has implemented programs such as Healthy Transitions and FEP (First Episode Psychosis). RI has been focusing on prevention and early intervention as the initial system of care. Table 1 Priority Areas and Annual Performance Indicator #4 shows the targets and outcomes for this population engaging in treatment services. Performance Indicator #1 shows percentage of youths engaging in substance use.

Gaps in treatment involved coordination of care between local agencies regarding admission and discharge. The quarterly System Review meetings assist with bridging the gaps and coordinating best practices by having multiple agencies present. The State of Rhode Island is using block grant funds to serve pregnant women and women with children through an MOU with the Department of Health (DOH). The program is Substance Exposed Newborns (SEN) Coordination Enhancement which connects pregnant women who are identified as at risk with SUD services. Table 1 Priority Areas and Annual Performance Indicator #6 shows the number of women engaging in services.

The “Blueprint to a Comprehensive Behavioral Health System of Care for Adults in Rhode Island” identified the unmet needs and critical gaps in Rhode Island’s current system and then discussed the state’s plan to address them. The Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis focused on prevention, crisis continuum, mental health treatment, substance use treatment, and recovery aftercare and community integration.

Regarding the crisis continuum, BH Link (the state’s walk-in crisis triage and stabilization facility), is serving fewer individuals in the state than originally anticipated, presumably, due to its location and the impact of COVID -19 and the impact on RI’s nursing workforce. Certified Community Behavioral Health Clinic (CCBHC) will provide the opportunity to assist with mobile crises statewide. Rhode Island’s 988 Lifeline, a national network that provides emotional support to people in suicidal crisis or emotional distress, has ranked among the top 3 local answer rates in the country. The state is in the process of funding an IT system that will help to coordinate all crisis response and referrals, in addition to providing new locations where people in crisis can physically go to.

The analysis of mental health treatment found that Mental Health Psychiatric Rehabilitative Residences (MHPRRs) are underfunded and lack pathways to less restrictive housing settings, long term care supports, and end of life care. CCBHC model will fill in gaps for crisis services and improve reimbursement rates for outpatient services. Improving rates for MHPRRs will allow for more individuals with mental health conditions to obtain and maintain housing. There is still a lack of affordable housing for individuals to move on to transition into once they no longer need MHPRR level of care. The Rhode Island Systems, Engagement, and Navigation (RISEN) grant, however, will provide services for individuals who are experiencing homelessness or at imminent risk of homelessness. Table 1 Priority Areas and Annual Performance Indicator #3 shows the target and outcomes for persons experiencing SMI who are connected with a mental health provider that are housed.

According to 2022 State Epidemiological Profile and SEOW, high school student suicide attempts were higher than expected across all sex, sexual orientation, and racial/ethnic groups. RI has implemented programs such as Healthy Transitions (HT) and First Episode Psychosis (FEP). HT and FEP provide services to young adults to assist with functional impairment their individual role or functioning in family, school, or community activities. These programs have been able to service clients that underinsured or uninsured. Table 1 Priority Areas and Annual Performance Indicator #4 shows the target and outcomes for youths newly enrolled in treatment services through HT.

According to 2022 State Epidemiological Profile and SEOW, from 2015-2020 mental health among young adults and adults has increased in the following indicators: serious mental illness (SMI), any mental illness, and had at least one major depressive episode. Integrated Health Home (IHH) and Assertive Community Treatment (ACT) provide service to the adult population experiencing SMI. Services include assisting with basic daily living, instrumental living, and participating in family, school, or workplace. IHH and ACT providing services to individuals with SMI has assisted with decreasing hospital readmission rates and ER visits. Table 1 Priority Areas and Annual Performance Indicator #5 shows the target and outcomes for CSP clients being re-admitted to the hospital and ER psychiatric admits.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Youth

Priority Type: SUP

Population(s): PP

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Reduce the percentage of youth ages 12-17 reporting 30-day use of alcohol, marijuana, prescription drugs, and electronic nicotine delivery system products (ENDS)

Baseline Measurement: 30 -day use of marijuana: 9.5%;; 30- day use of alcohol: 9.0%; 30-day use of e-cigarettes 9.1%; 30-day non-medical use of prescription medication 2.0%

First-year target/outcome measurement: Maintain the percentages of 30 day use of alcohol, marijuana, prescription drugs,, and ENDS products by junior high/middle school and high school students in municipalities across the state.

Second-year target/outcome measurement: One percentage point decrease in reported 30-day use of alcohol, marijuana, and ENDS products and continue to maintain percentage for prescription drugs by junior high/middle school and high school students in municipalities across the state.

Data Source:

Rhode Island Student (RISS)

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.

Data issues/caveats that affect outcome measures:

Indicator #: 2

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

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

First-year target/outcome measurement: Maintain the perception of risk of harm for substances (based on baseline)

Second-year target/outcome measurement: Increase perception of risk of harm for substances by 3% (based on first year target)

Data Source:

Rhode Island Student Survey

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.

Data issues/caveats that affect outcome measures:

Priority #: 2

Priority Area: Persons Who Inject Drugs

Priority Type: SUT, SUR

Population(s): PWID

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: 1,364

First-year target/outcome measurement: 1,430

Second-year target/outcome measurement: 1,500

Data Source:

Recovery Community Center reporting to the BHDDH Contract Monitoring Unit

Description of Data:

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

Data issues/caveats that affect outcome measures:

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

Indicator #: 2

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

Baseline Measurement: 37,207

First-year target/outcome measurement: 39,000

Second-year target/outcome measurement: 40,900

Data Source:

Recovery Community Center reporting to the BHDDH Contract Monitoring Unit

Description of Data:

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

Data issues/caveats that affect outcome measures:

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

Priority #: 3

Priority Area: Individuals Experiencing Homelessness

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: 87%

First-year target/outcome measurement: 87%

Second-year target/outcome measurement: 89%

Data Source:

BHOLD

Description of Data:

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

Data issues/caveats that affect outcome measures:

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

Priority #: 4

Priority Area: Children and Youth Experiencing Early Serious Mental Illness/first Episode Psychosis

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Ensure children and youth have access and are receiving behavioral healthcare services.

Strategies to attain the goal:

The Healthy Transitions program will provide services to children and youth, ages 15 up to 18, throughout Rhode Island. Each HT location will provide services to children and youth, 15 through 17 years old via block grant funds. The block grant funds will also be used to provide services to uninsured and underinsured for all ages.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth ages 15 through 17 newly enrolled in treatment services through the Healthy Transitions Program.

Baseline Measurement: 42 individuals, aged 15-17, were newly enrolled into HT during 2022

First-year target/outcome measurement: 42 individuals

Second-year target/outcome measurement: 50 individuals

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

N/A

Priority #: 5

Priority Area: Adults Diagnosed with SMI

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: 262 readmits per 1,000

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

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

Data Source:

MMIS

Description of Data:

Medicaid claims data for CSP members

Data issues/caveats that affect outcome measures:

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

Indicator #: 2

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

Baseline Measurement: 108 admissions per 1,000 clients

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

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

Data Source:

MMIS

Description of Data:

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

Data issues/caveats that affect outcome measures:

N/A

Priority #: 6

Priority Area: Women and children

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: 336

First-year target/outcome measurement: 360

Second-year target/outcome measurement: 370

Data Source:

Program data sent to the program liaison.

Description of Data:

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

Data issues/caveats that affect outcome measures:

n/a

Indicator #: 2

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

Baseline Measurement: 156

First-year target/outcome measurement: 165

Second-year target/outcome measurement: 175

Data Source:

Data submitted to the program liaison.

Description of Data:

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

Data issues/caveats that affect outcome measures:

N/A

Priority #: 7

Priority Area: Referrals from first responders to the triage center

Priority Type: MHS

Population(s): BHCS

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: 41 referrals from 1st responders to the triage center

First-year target/outcome measurement: 50 referrals from 1st responders to the triage center

Second-year target/outcome measurement: 60 referrals from 1st responders to the triage center

Data Source:

Direct reporting from BH Link to BHDDH Project Manager.

Description of Data:

Each person referred from a first responder.

Data issues/caveats that affect outcome measures:

N/A

Priority #: 8

Priority Area: Young Adults Experiencing Early Serious Mental Illness/first Episode Psychosis

Priority Type: ESMI

Population(s): ESMI

Goal of the priority area:

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

Strategies to attain the goal:

The Healthy Transitions program will provide services to young adults, ages 18 to 26, throughout Rhode Island. Each HT location will provide services to 18 to 26 years old via Medicaid funding. The block grant funds will be used to provide services to uninsured and underinsured for this age group.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of young adults, ages 18-26, newly enrolled in treatment services through the Health Transitions Program

Baseline Measurement: 70 individuals, aged 18-26, were newly enrolled into HT during 2022

First-year target/outcome measurement: 70 individuals, aged 18-26, are to be newly enrolled into HT during 2023

Second-year target/outcome measurement: 75 individuals, aged 18-26, are to be newly enrolled into HT during 2024

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

N/A

Priority #: 9

Priority Area: Persons with Tuberculosis

Priority Type:

Population(s): TB

Goal of the priority area:

To reduce the incidence of tuberculosis in RI

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Case rate of tuberculosis in RI

Baseline Measurement: 1.3 cases per 100,000

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

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

Data Source:

RIDOH TB Reporting

Description of Data:

Cases per 100,000 of TB as reported to RIDOH

Data issues/caveats that affect outcome measures:

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

Footnotes:

Indicator #4 Healthy Transitions (HT) is a program for youth who experience ESMI, SED, and FEP. HT offers access to wrap around services that include a substance abuse specialist.

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$7,905,711.00		$0.00	$17,281,886.00	$18,486.52	$0.00	$0.00		$4,962,606.00	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$252,567.00						$0.00		$300,000.00	
b. Recovery Support Services	$4,529,005.00			$6,569,373.00			$0.00		$408,716.00	
c. All Other	$3,124,139.00			$10,712,513.00	$18,486.52		$0.00		$4,253,890.00	
2. Primary Prevention[d]	$6,880,661.00		$0.00	$11,747,832.00	$0.00	$400,000.00	$0.00		$1,803,401.00	$0.00
a. Substance Use Primary Prevention	$6,880,661.00			$11,747,832.00		$400,000.00	$0.00		$1,803,401.00	
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services										
6. Early Intervention Services for HIV										
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$778,230.00				$2,859,692.56				$356,106.00	
12. Total	**$15,564,602.00**	**$0.00**	**$0.00**	**$29,029,718.00**	**$2,878,179.08**	**$400,000.00**	**$0.00**	**$0.00**	**$7,122,113.00**	**$6,150,916.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Footnotes:
The planned expenditures are part of the approved plan by department leadership and state budget office.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: Planning Period End Date:

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]											
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$676,212.80		$561,894.00				$92,704.64		$771,000.00	
4. Other Psychiatric Inpatient Care											
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital											
8. Other 24-Hour Care											
9. Ambulatory/Community Non-24 Hour Care		$4,741,809.20		$1,368,174.00				$584,039.19		$2,638,719.98	
10. Crisis Services (5 percent set-aside)[f]		$1,006,000.00						$203,950.20		$1,400,000.00	
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$338,106.00		$419,738.00	$2,878,060.00			$46,352.32		$253,143.16	
12. Total	**$0.00**	**$6,762,128.00**	**$0.00**	**$2,349,806.00**	**$2,878,060.00**	**$0.00**	**$0.00**	**$927,046.35**	**$0.00**	**$5,062,863.14**	**$203,204.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[d]While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Footnotes:
The future expenditures are part of the approved plan by the departmental leadership and the state budget office.

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	37,838	146
2. Women with Dependent Children	57,913	1,500
3. Individuals with a co-occurring M/SUD	87,859	15,003
4. Persons who inject drugs	17,875	3,713
5. Persons experiencing homelessness	1,577	816

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

Calculations 1. Pregnant women a. % of RI adults 18+ with SUD= 19.13% (2021 NSDUH; 2021 survey asks about prescription drug use) b. # of RI females ages 18-44 = 197,796 (Estimated 2021 Census) c. Calculation: 197,796 x 0.1913 = 37,838 2. Women with Dependent Children a. % of RI adults 18+ with SUD = 19.13% (2021 NSDUH; 2021 survey asks about prescription drug use) b. # of RI females ages 18-60 = 302,734 (Estimated 2021 Census) c. Calculation: 302,734 x 0.1913 = 57,913 3. Individuals with a co-occurring M/SUD a. % of youth 12-17 with co-occurring SUD and MDE = 2.7% (2020 NSDUH) b. % of adults 18+ with co-occurring SUD and AMI in Northeast = 6.2% (2020 NSDUH) c. # of RI residents ages 10+ = 987,184 (Estimated 2020 Census)_The aggregate number in treatment reflects the number of individuals in BHOLD who received behavioral health treatment at a BHDDH licensed facility and who reported being homeless or living in a shelt d. Calculation: 987,184 x (0.027 + 0.062) = 87,859 4. Persons who inject drugs a. % of adults 18+ who have ever injected drugs= 2.01% (2020 NSDUH) b. # of RI adults aged 18+ = 890,299 (2022 Census estimate) c. calculation: 890,299 x (0.0201) = 17,875 5. Homelessness: The aggregate estimated number in need was gathered from HUD's 2022 Annual Homelessness Report to Congress. Due to limited data

on this topic, this number reflects the number of individuals estimated to be experiencing homelessness and does not reflect the number of individuals experiencing homeless who have SUD. The aggregate numbers in treatment were collected from our Behavioral Health Online Database and represents individuals who received behavioral health treatment at a BHDDH licensed facility between July 1, 2022- June 30, 2023

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Footnotes:

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$3,683,984.92	$206,550.00	$2,609,969.59
2 . Substance Use Primary Prevention	$3,455,118.18	$171,137.00	$2,162,482.44
3 . Early Intervention Services for HIV[4]			
4 . Tuberculosis Services			
5 . Recovery Support Services[5]	$260,063.00	$30,381.00	$383,898.97
6 . Administration (SSA Level Only)	$383,134.90	$21,477.00	$271,387.00
7. Total	**$7,782,301.00**	**$429,545.00**	**$5,427,738.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[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 FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

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

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Footnotes:

These figures are based on full grant award for the base block grant and on the remaining balances as of 10/1/23 for the covid supplemental award and the ARP award. The covid supplement and ARPA figures are reflective of the anticipated spend based on the approved state plan.

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
2. Education	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
3. Alternatives	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
4. Problem Identification and Referral	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
	Universal			

5. Community-Based Processes	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
6. Environmental	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
7. Section 1926 (Synar)-Tobacco	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$0**	**$0**	**$0**
Total SUPTRS BG Award[3]		**$7,782,301**	**$429,545**	**$5,427,738**
Planned Primary Prevention Percentage		**0.00 %**	**0.00 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

No SYNAR expenditures are expected to be charged to the SUPTRS Block Grant.

Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$4,669,381	$386,591	$3,907,971
Universal Indirect	$2,723,805	$30,068	$1,194,102
Selected			
Indicated	$389,115	$12,886	$325,665
Column Total	**$7,782,301**	**$429,545**	**$5,427,738**
Total SUPTRS BG Award[3]	**$7,782,301**	**$429,545**	**$5,427,738**
Planned Primary Prevention Percentage	**100.00 %**	**100.00 %**	**100.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

The projected expenditures are based on the approved plan. These costs include applicable resource development.

Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☐	☐	☐
Heroin	☐	☐	☐
Inhalants	☐	☐	☐
Methamphetamine	☐	☐	☐
Fentanyl	☐	☐	☐
Prioritized Populations			
Students in College	☑	☑	☐
Military Families	☐	☐	☐
LGBTQI+	☑	☑	☑
American Indians/Alaska Natives	☐	☐	☐
African American	☑	☑	☑
Hispanic	☑	☑	☑
Persons Experiencing Homelessness	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☐	☐	☐

Underserved Racial and Ethnic Minorities	☐	☐	☐

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

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Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [SUPTRS]

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems		$77,901.00			
2. Infrastructure Support	$248,412.00	$137,825.00		$5,404.00	$79,354.00
3. Partnerships, community outreach, and needs assessment	$61,013.00	$23,969.00			
4. Planning Council Activities (MHBG required, SUPTRS BG optional)					
5. Quality Assurance and Improvement	$13,074.00				
6. Research and Evaluation		$155,802.00		$5,085.00	$74,685.00
7. Training and Education	$113,310.00	$203,740.00		$5,404.00	$79,354.00
8. Total	**$435,809.00**	**$599,237.00**	**$0.00**	**$15,893.00**	**$233,393.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Footnotes:

The future expenditures are based on the approved plan. These expenditures are in the appropriate categories on form 4.

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: 09/30/2023 MHBG Planning Period End Date: 09/29/2025

Activity	FY 2024 Block Grant	FY 2024[1] COVID Funds	FY 2024[2] ARP Funds	FY 2024[3] BSCA Funds	FY 2025 Block Grant	FY 2025[1] COVID Funds	FY 2025[2] ARP Funds	FY 2025[3] BSCA Funds
1. Information Systems	$105,286.00				$105,286.00			
2. Infrastructure Support								
3. Partnerships, community outreach, and needs assessment	$111,136.00	$37,907.00			$111,136.00			
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$76,040.00				$76,040.00			
5. Quality Assurance and Improvement								
6. Research and Evaluation	$111,136.00	$35,487.00	$40,933.00		$111,136.00		$40,933.00	
7. Training and Education	$181,326.00	$7,259.00	$12,227.00	$20,320.40	$181,326.00		$12,227.00	
8. Total	**$584,924.00**	**$80,653.00**	**$53,160.00**	**$20,320.40**	**$584,924.00**	**$0.00**	**$53,160.00**	**$0.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Footnotes:

The anticipation is that all Covid Supplemental funds will spend in FY24 so there aren't any allocations for FY25. The allocations for ARP Funds are split in half because there are still two full years of potential expenditures. BSCA funds do not play a roll in systems development therefore these two columns are left as zero.

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

RI has been focused on improving the range and quality of available services by improving access to care for mental disorders, substance us disorders and co-occurring disorders to ensure that people are first and foremost made aware of services to access. Paid media campaigns have focused on a variety of topics and information, some on how to access programs such as "988", our Substance Exposed Newborns programs or just how to find treatment and recovery within our own community. Published calendar events include how and where to visit a mobile van that can provide immediate SUD/ MOUD treatment services. A recent news article touted the new RI Outreach (RIO) program that supports mental health mobile crisis work at hotspots in the community. Educational seminars, Narcan distribution and prevention workgroups provide increased awareness directly in the community. Our sister state agencies such as the Department of Health, The Department of Children and Family Servies (DCYF) and the RI Department of Corrections meet regularly with BHDDH to address Behavioral Healthcare issues such as the overdose crisis, re-entry populations and transitional and treatment issues. The focus of these meetings has been on SAMSHA's priority populations and what that means when access to care is needed even if someone is uninsured or undocumented.
Rhode Island's outreach work has increased because we have listened to people with lived experience, we needed to make improvements on meeting people where they are, despite having great success with our 24/7 triage call walk-in center called BHLink. BHLink has been a deterrent from client with a substance use or a mental Health condition or a Co-Occurring condition to have to wait long hours in our emergency rooms. We have been committed to offering information on harm reduction materials, HIV and TB testing and mobile van services targeting wound care, screening for physical health, and providing treatment for MOUD services. Capacity building has been increasing with three new SUD treatment facilities coming on board and we look forward to the implementation of CCBHC's and have been actively working on the development of CCBHC certification standards. We have increased outreach and engagement efforts to adults with SMI and SUD to the unhoused to connect with treatment via expanded outreach. We have increased our funding for coordinated specialty care to reach more transitional aged youth. This has allowed the program to be in all parts of the State.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

RI Medicaid asked the RI Commissioner of the Office of Health Insurance (OHIC) to conduct exams of all four major commercial health insurers operating in RI to ensure that Behavioral Health care is covered at parity with physical health care- consistent with federal and state law. This has led to an increased awareness and accountability for parity protections.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

RI supports integrated behavioral healthcare and primary health care through programs such as the Health & Justice Transformation program. The Lifespan Transitions Clinic (LTC) is an interdisciplinary, primary care-based program serving individuals recently released from incarceration in Rhode Island. Located at the Rhode Island Hospital Center for Primary Care, the LTC provides medical care and peer-driven reentry support to formerly incarcerated patients with chronic medical conditions. The CHJT employs a Medical Discharge Planner, based at the RI Department of Corrections, who can refer patients to the program while they are still incarcerated, and develops safe release plans for patients with terminal and serious illnesses. Transitions Clinic patients are seen for their first appointment within two weeks of their release, at which point they establish with a primary care provider and with a community health worker (CHW) and a MOUD program as clinically appropriate. All Transitions Clinic have peer staff with a history of incarceration and work one-one-with individuals to help them navigate the healthcare and social service systems while also providing peer support and mentorship.

RI has also embedded Opioid Treatment Programs within several Community Mental Health Organizations, the RI Department of Corrections and FQHC's.
The health home model incorporates care coordination in all domains in an SMI client's life. The State has 2 health homes for adults with SMI impacting their level of functioning which are an integrated health home and the assertive community treatment program. These are our most intensive community-based services that utilizes a multi-disciplinary approach to treatment.

CMHCs refer clients to primary care providers and may assist with coordination, scheduling, and transportation. The primary care providers are typically in the same catchment area of the agency assisting with coordination. The agencies usually have working relationships which help to assist the client.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

The RI SUD system has a multitude of options for treatment especially for a small state that only covers 1,545 square miles. It starts with access. Our 17 OTP locations do not have a wait list for admissions. Our hotlines such as 988, the BHlink 24/7 call line, a 24-7

physician manned buprenorphine hotline and even a recovery housing hotline. Most are funded through some type of braided funding thus maximizing opportunities. We utilize Medicaid, Managed Care, federal grants, general state revenue and even most recently abatement funds from a settlement with TEVA pharmaceuticals.
For serious SUD cases RI has OTP Health Home teams that coordinate MOUD services for those with physical and more intense mental health conditions. Centers of Excellence programs support complex buprenorphine cases and offer education and care coordination to physicians that need counsel and support for cases that might need more wrap around services than they feel they can offer. RI also offers every ASAM level of residential care including a new program being piloted called "Safe Landings' This program will serve as a "gap" program for individuals who may have overdosed multiple times but are not ready to enter a residential or a MOUD program. Safe Landings will be a 30-day residential peer respite program with appropriate clinical oversite focused on the 8 Dimensions of Wellness and client directed services, including providing basic needs and harm reduction materials and education.
The above, hotlines such as 988 and the BHlink 24/7 call line, predominately serve SMI adults and children with SED. The state has implemented children's mobile response, targeting children with SED. In addition to this new program serving as hospital diversion function, the program opens a caseload to support the family while care coordination efforts and referrals are completed. This program bridges the gap for children with SED until home services are available.

Adults with SMI and children with SED that are engaged in services at a CMHC have access to ACT, IHH, or HT teams that feature care coordination. These programs provide care coordination by providing wrap around services involving therapy, vocational, substance, and psychiatry. These services are funded through Medicaid, commercial, block grants, or Title XX.
If an individual receives care coordination externally, the team can assist with scheduling appointments, assisting with transportation options, assisting with communication with the provider ie. telephone or at the office, etc.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Working with Medicaid and the Department of Children, Youth, and Families (DCYF), BHDDH has created our vision of an accessible, equitable, and sustainable behavioral health system for all. The goal of RI's CCBHC's will be to expand the network of community providers who have the capacity to become a CCBHC and/or partner with a CCBHC as a Designated Collaborating Organization (DCO) to support the goal of improving the entire RI Behavioral Healthcare system. This system will support adults with SMI and children with SED.
The certification process already established is based on SAMSHA standards and criteria. Staffing teams will be built on evidence-based models such as IDDT. The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice that improves quality of life for people with co-occurring severe mental illness and substance use disorders by combining substance abuse services with mental health services. It helps people address both disorders at the same time—in the same service organization by the same team of treatment providers.
IDDT emphasizes that individuals achieve big changes like sobriety, symptom management, and an increase in independent living through a series of small, overlapping, incremental changes that occur over time. Therefore, IDDT takes a stages-of-change approach to treatment, which is individualized to address the unique circumstances of each person's life.
The process of Certifiying the CCBHCs, our sister organization, DCYF, sets at the table to ensure children's needs at being incorporated to address the need. Student Assistance is one of our largest programs, addressing school aged children. NAMI has established a Peer to Peer program in the school system to meet the needs of children experiencing a mental health issue.

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

RI needs to improve our youth behavioral healthcare system. So much focus has been targeted on adult behavioral health that it is time for RI to consider revamping our entire youth BH system. We would like to learn from other states that have robust mental health, substance use disorder/Co-Occurring treatment system on how we could move toward improvements. We have invested heavily in prevention, but our child and adolescent treatment seems to focus solely on acute mental healthcare.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf**

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race ◉ Yes ○ No

b) Ethnicity ◉ Yes ○ No

c) Gender ◉ Yes ○ No

d) Sexual orientation ◉ Yes ○ No

e) Gender identity ◉ Yes ○ No

f) Age ◉ Yes ○ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ◉ Yes ○ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ◉ Yes ○ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ◉ Yes ○ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? ◉ Yes ○ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ◉ Yes ○ No

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

All of our settlement funds and contracts require culturally and linguistically appropriate service standards.

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center (EBPRC) assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

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

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

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

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

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

[5] **https://www.samhsa.gov/ebp-resource-center/about**

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☐ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☐ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☐ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☑ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

majority of our value based purchasing is done through CMS and Medicaid.

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

Any technical assistance offered would be of value to the State of Rhode Island.

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

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

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

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

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Coordinated Specialty Care	7

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
900000	900000

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

Our sites currently bill both Medicaid and other insurances. Our programs enroll 15-26 year olds and the billing for both Medicaid and commercial insurers varies depending on the coverage and age of the program participant. For example: Medicaid billing through Health Homes or ACT can be done for those individuals over 18 and enrolled in Medicaid. We access children's intensive services for those enrolled in Medicaid that are under 18.
Accessing commercial insurance varies from carrier, but we strive to submit services that are allowed. These include the following intensive services for children (and adults with BCBS-RI):
• Diagnostic evaluation
• Individual and family home-based therapy
• Skills development and coaching (home based)
• Care coordination with client present
• Care coordination without client present – BCBS only
• Medication management with and without therapy

Outpatient services for adults and children:
• Diagnostic evaluation
• Individual, family, and group center-based therapy
• Medication management with and without therapy

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

Healthy Transitions is a program for youth and young adults, ages 16-25 who are experiencing ESMI, SMI, SED, with an emphasis on FEP. Programs offer access to clinicians, a wraparound case manager, nurse, prescriber, substance use disorder specialist, and an employment education specialist who work as a team to assist participants with meeting personal goals for improving mental health and making successful transitions to adulthood. Youth and young adults will receive help with managing their mental illness through the development of an individualized recovery plan that is developed through shared decision making with the individual. These recovery plans can include treatment goals, goals for housing, employment, education, care, and support. HT has an exception process to allow individuals experiencing prodromal symptoms that have not yet met the criteria for a disorder. This process allows for ongoing assessment and intervention throughout the diagnostic process. Services for individuals without an ESMI diagnosis are funded through services outside of the MHBG.

5. Does the state monitor fidelity of the chosen EBP(s)?

○ Yes ◉ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

◉ Yes ○ No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

We increase access by conducting outreach with our community partners. These include schools, community agencies, parent groups, and hospitals. Because it's a team-based approach, members of the team provide supports within their scopes of practice while working together as a team to ensure that the individual treatment plans are developed and implemented. Working as a team, they address issues as they arise and collaborate to work with the individual and their family. HT provides developmentally appropriate services to eligible youth and young adults. (I have reached out to Julie to see what our outcomes data for all baselines to 6-months interviews show.)

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

In FY 25, we will add an additional two Healthy Transitions team in which we will utilize block grant dollars to fund this service when their insurance does not provide this benefit.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

Diagnostic categories (copied from Newport/TPC scope of work):
• Schizophrenia and Other Psychotic Disorders,
• Bipolar Disorders,
• Depressive Disorders
• Anxiety Disorders
• Obsessive Compulsive Disorders
• Conduct disorders (ODD only 18 and younger),

• Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence.

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

Statewide prevalence of adult SMI was calculated using the 2021 NSDUH estimate for adults aged 18+ with SMI in Rhode Island, 5.99%. This percentage was multiplied by SAMHSA's population estimate of adults aged 18+ in RI based on 2021URS reports, 883,380 people. Statewide incidence of SMI was calculated using 2022 data from BHOLD. From January to December of 2022, there were 2,549 unique new admissions of adults aged 18+ in RI with SMI who were enrolled in a MH program and did not have a prior admission in BHOLD. A rate of 100,000 per year was calculated by dividing this number of new admissions by the 2022 census estimate of adults aged 18+ in RI.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

By increasing the number of agencies providing this service, this allows additional clients throughout the state to have the opportunity to participate in this program. Additionally, the BHDDH's Youth Coordinator participates in outreach and engagement activities with youth programs throughout the state.

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

Rhode Island is currently receiving technical assistance from a SAMHSA consultant for programming for children with serious emotional disturbance.

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Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for MHBG

Narrative Question

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

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

The State Mental Health Authority, BHDDH, has licensing regulations established for the purpose of adopting prevailing standards for the licensure and operation of facilities and programs providing behavioral health services for adults. Furthermore, the regulation states that "it is the expectation of the Department that each person's array of supports and services be customized to meet the individual's needs and desires in the least restrictive environments possible." (212-RICR-10-10-1)

Regulation defines a person- centered plan as the written plan that results from a collaborative process between the person served and the service provider that describes the activities and services that will guide the individual’s efforts toward recovery and incorporates information collected during the assessment. It is also called the treatment plan.
The treatment team leader is responsible for the implementation and review of the individualized person-centered plan, for the coordination of service delivery from other service providers and for the review of progress notes and discharge summary.

4. Describe the person-centered planning process in your state.

The State of Rhode Island believes that Person-centered planning strives to place the individual at the center of decision-making. It is based on the values of human rights, interdependence, choice, and social inclusion, and can be designed to enable people to direct their own services and supports, in a personalized way. Person-centered planning isn't one clearly defined process, but a range of processes sharing a general philosophical background and aiming at similar outcomes. Furthermore, person centered planning is also a process directed by an individual, with impartial assistance when helpful, focusing on their desires, goals, needs, and concerns to develop supports to live a meaningful life maximizing independence and community participation.
The State first accomplishes this goal by incorporating those with lived experiences into decision making forums. At all levels, agency, municipal and state government, persons with lived experience are required members with decision making authority. Secondly, the state requires agreement for plans from the person being served. In very limited situations, agreement is not required.
Person-centered planning is an individualized approach to planning that supports an individual to share his or her desires and goals, to consider different options for support, and to learn about the benefits and risks of each option. Although the process must be customized differently for each person, the following guidelines summarize universally accepted “operating principles” for person-centered planning:
1. The individual is the focus of the planning process and involved in decision making at every point in the process, including deciding how and where planning will take place. Decisions made in the planning process can be revisited whenever the person wants.
2. The individual decides who to invite to the planning team. Planning teams include those who are close to the person, as well as people who can help to bring about needed change for the person and access appropriate services.
3. Planning team members help to identify and foster natural supports. Natural supports include family, friends, community

connections, and others in the person's social network. Development of natural supports is encouraged by inviting family members, friends, and allies to participate in planning meetings.
4. The planning team explores informal and formal support options to meet the expressed needs and desires of the individual. Informal supports—family, friends, neighbors, church groups, and local community organizations—are considered first. These natural supports are supplemented by formal services, including services such as personal care services, adult day services, residential services, home care services, nursing services, Meals on Wheels, and caregiver supports.
5. The individual can express his/her needs, desires, and preferences and to make choices. Appropriate accommodations should be made to support the individual's meaningful participation in planning meetings.
6. Some individuals may require assistance in making choices about their individual plans and their supports and services. In these cases, the individual still participates in the person-centered planning process and makes all decisions that are not legally delegated to a guardian or other substitute decision maker.
7. The process shifts power and budgeting to the individual with proper support when necessary or requested.
8. The process develops real choice for the individual, not only options of currently available programs.
9. Communications by the individual, including non-verbal communication such as expression, behavior, and mood are considered and respected

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

RI does not currently have a statue for a psychiatric advanced directive.

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

N/A

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

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

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

Please respond to the following:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

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

To ensure that contracts are monitored for program integrity, the Department has moved to a new model of contract monitoring in which a clinical program liaison has been assigned to each program funded through the block grant. The clinical program liaison will ensure compliance with the scope of work and to ensure all f in addition to the contract monitor whose responsibilities are to monitor the contract to ensure proper expenditures and this new model ensures that the contract is monitored from a multidiscipline approach leading to a more comprehensive contract monitoring process.

Please indicate areas of technical assistance needed related to this section

N/A

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

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

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

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   We have not consulted with actual tribe members. But we have had regular conversations with the social worker in charge of the tribal clinics. there is 1, 852 total Native Americans in Rhode Island. The total population of RI as of the 2022 census is 1,093,734.

2. What specific concerns were raised during the consultation session(s) noted above?

   Concerns over the tribe having enough resources such as educational materials and naloxone. We wanted to support and encourage them to participate in the Governor's Overdose Task Force.

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

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

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

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

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☐ Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** ☑ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Cultural/ethnic minorities
- **g)** ☑ Sexual/gender minorities
- **h)** ☐ Rural communities
- **i)** ☐ Others (please list)

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

- **a)** ☐ Archival indicators (Please list)
- **b)** ☑ National survey on Drug Use and Health (NSDUH)
- **c)** ☑ Behavioral Risk Factor Surveillance System (BRFSS)
- **d)** ☑ Youth Risk Behavioral Surveillance System (YRBS)
- **e)** ☐ Monitoring the Future
- **f)** ☐ Communities that Care
- **g)** ☑ State - developed survey instrument
- **h)** ☐ Others (please list)

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

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

  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
- **b)** If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step? ◉ Yes ○ No

- **a)** If yes, please explain in the box below.

  BHDDH requires our regional coalitions to perform a Needs Assessment every 3 years. They look at sub population data to determine population level need, impact of consequences, consumption patterns, and risk/protective patterns to advance health equity and to help eliminate health disparities.
- **b)** If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? ◉ Yes ○ No

- **a)** If yes, please explain in the box below.

  BHDDH requires prevention providers to describe how key tasks associated with the assessment step will be sustained beyond the funding from federal funds.

b) If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

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

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe.

Rhode Island has a certification board for three certifications: Associate Prevention Specialist (APS), Certified Prevention Specialist (CPS), and Advanced Prevention Specialist (ACPS). The website is: https://www.ricertboard.org/

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe mechanism used.

BHDDH contracts with the RI Prevention Resource Center (RIPRC) which is the training and technical assistance center for Rhode Island prevention specialists. The website is: https://www.riprc.org/

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

a) If yes, please describe mechanism used.

BHDDH performs a Request for Proposal procurement or Delegated Authority process. Our prevention providers are required to submit a formal application to request funds. Our technical review team performs an evaluation of the proposal by scoring each section and requiring that they follow the steps of the Strategic Prevention Framework (SPF) process in their application.

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

Delegated authority: The Department sought and received delegation of contracting authority in pertaining to the disbursement of grant funding to Regional Substance Abuse Prevention Task Forces for cost associated with activities or services designed to prevent substance misuse/abuse within Rhode Island's cities and towns. These activities or services include assessing prevention needs and resources, building capacity to implement evidence based or evidence informed interventions and strategies, creating service delivery plans, delivering services and monitoring or evaluating the impact of activities and services provided.

Delegated authority permits the Department to award funding to all agencies classified as a regional substance abuse prevention task force by BHDDH through a funding formula based on a per capita basis or rates of consumption, for example, a formula funding based on high need as described by high levels of negative consequences associated with substance use/misuse (such as rates of opioid overdose within the region) or high rates of substance misuse or use. The delegated authority is derived from Rhode Island General Law 16-21.2 which establishes substance abuse prevention programs and establishes BHDDH as the vehicle to administer funding. Rhode Island General Law 40.1-1-13 defines the powers and duties of BHDDH in developing, providing for and coordinating the implementation of a comprehensive state plan for substance abuse education, prevention and treatment. Furthermore, Rhode Island General Law 40.1-1-13 (8) specifically empowers the BHDDH to act in the capacity of the Substance Abuse and Mental Health Authority. The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals is the federally authorized co-Single State Agency for Substance Abuse Services.

This designation allows the Department the unique capacity to understand the clinical and environmental needs of the community and ensure access to the opportunity to administer federal funding both through the federal block grants and competitive discretionary grants.

4. Does your state integrate the National CLAS Standards into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

BHDDH requires our regional coalitions to perform a Needs Assessment every 3 years. They look at sub population data to identify capacity needs, ensure representation on the coalition, relevant recruitment or outreach strategies, community readiness, mobilization or capacity building strategies, and prevention programming capacity needs to advance health equity and to help eliminate health disparities.

5. Does your state integrate sustainability into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

BHDDH requires our providers to develop a process for sustaining use data to select community level priority consequences, related consumption patterns and risk or protective factors to target with strategies.

b) If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

Uploaded the Rhode Island Strategic Plan into the Attachments Page.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG? (●) Yes ( ) No ( ) N/A

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

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [ ] Cultural competence component (i.e., National CLAS Standards)
- **g)** [ ] Sustainability component
- **h)** [ ] Other (please list):
- **i)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

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

The Evidence Based Practices Workgroup is being convened under the auspices of the Governor's Council on Behavioral Health's

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

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

7. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

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8. Does your state integrate the National CLAS Standards into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

BHDDH requires our regional coalitions to perform a Needs Assessment every 3 years. They look at sub population data to include the needs in their strategic plan, process for how culturally relevant evidence-based programs were selected, identify forma or informal processes to solicit participation from sub populations in preparation of the strategic plan or selection of the evidence based programs, and include training or professional development requirements related to cultural competency for staff or subcontractors to advance health equity and to help eliminate health disparities.

b) If no, please explain in the box below.

N/A

9. Does your state integrate sustainability into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

BHDDH requires our providers to develop a process for sustaining key tasks associated with planning, identifying effective strategies/evidence-based programs to meet community need, and preparation of their strategic plan.

b) If no, please explain in the box below.

N/A

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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

Implementation

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

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

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

The Regional Prevention Task Force (RPTF) coalitions develop and plan health fairs, media campaigns, brochure, resource directories, Public Service Announcements. One particularly successful statewide event is National Drug Take Back. Drug Take Back events are held in many communities throughout the state twice annually and launched with a press conference to gain additional exposure. It is one way to inform the general public of the need to clean out medicine cabinets. The rates of prescription drug abuse are alarmingly. We know that most youth get their prescription medicines from a family member or friend, including the home medicine cabinet, and often without their knowledge. There are permanent drug drop off boxes in most the our Rhode Island police departments. We are getting the message out that this is the safest way to dispose of unused medications. Several coalitions have implemented a Count it, Lock it, Drop it campaign targeting prescription and over the counter medicine to ensure that they are secure and limit access to family members. Lock Bags are being distributed to safely lock up prescriptions or over the counter mediciine to prevent unintentional poisonings and access to youth. They have also implemented 988 campaigns to encourage individuals to look for signs of depression and suicidality in their peers and community members. The political landscape in Rhode Island has shifted to legalization

of
recreational use of marijuana in 2023. RPTF coalitions are working with the marijuana dispensaries to ensure that identification checks are being performed. Information on the harmful effects of marijuana are distributed across the state through the regional prevention task forces. Marijuana Lock Bags are being distributed to safely lock up marijuana to prevent unintentional poisonings and access to youth. Underage drinking continues to be a high levels although we saw some decreases recently. The RPTF coalitions continue to work with the alcohol retailers and providing the best practices on performing identification checks, responsible beverage sever training, display signage deterring underage serving and purchase, utilize sticker shock campaigns. The Drug Take Back initiative continues to be a successful initiative collecting unwanted or unused medications twice annually.

b) Education:

RPTF coalitions fund evidence-based classroom, small group sessions, parenting/family classes, education programs that they will use for the youth within their communities. Several coalitions that were previously funded by BHDDH have continued to implement their evidence-based programs within their schools such as: Towards No Drug Use, Life Skills, Too Good by institutionalizing the curriculum through the health teachers. Newer evidence-based programs more recently implemented include Strengthening Families, Familias Unidas, Project Alert, Above the Influence, Family Matters, Communities Mobilizing for Change on Alcohol, Third Millenium, and Delta 9.

Our student assistance program provides the PROJECT SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) Prevention Education Series. PROJECT SUCCESS an alcohol, Tobacco and Other
Drug prevention program conducted by a master's Level Student Assistance Counselor (SAC) with small groups of students in over 70 Rhode Island middle and high schools. Our student assistance program is also implementing a program, Teen Institute. Rhode Island Teen Institute (RITI) is a statewide leadership and prevention program that targets high school-aged peer leaders, whether traditional or nontraditional, from a broad range of community settings, training them in individual and community advocacy, decision-making, and interpersonal and leadership skill development. RITI reinforces leaders' commitment to a healthy lifestyle and organizes their peers to advocate for prevention in their communities. Teen Institute does not seek to establish Teen Institute groups in schools and communities, but encourages participants to join existing youth groups focused on health and substance abuse prevention issues facing youth.

c) Alternatives:

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

d) Problem Identification and Referral:

Rhode Island Student Assistance Services (RISAS) is the primary provider for student services. The Rhode Island Junior High/Middle School Student Assistance Act (R.I. General Laws 16-21.3) was established by the Rhode Island General Assembly in 1989. The Statute authorized funding to establish student assistance programs (SAPs) in junior high and middle schools throughout the state. Student Assistance is modeled on employee assistance programs (EAPs), SAPs focus on behavior and performance at school, using a process to screen students for alcohol, and other drug problems. The counselor provides early identification, comprehensive assessment, intervention and referral, if necessary, to adolescents who are experiencing high risk behaviors. The counselor also acts as a liaison between the school and school personnel, parents and a variety of community agencies. This model enables a school to more effectively and efficiently carry out its function of educating students. BHDDH contracts with RI Student Assistance Services (RISAS) to provide school and community-based substance abuse prevention and early intervention services to Rhode Island schools and communities. RISAS is implementing Project SUCCESS, an evidence-based SAMHSA program, in over 40 Rhode Island middle and high schools. Project Success utilizes a combinations of interventions, which include the following:
- The Prevention Education Series- an Alcohol, Tobacco and Other Drug prevention program conducted by a Student Assistance Counselor (SAC) with small groups of students
- Individual and Group Counseling- Student Assistance Counselors conduct time limited individual and group sessions at school with students, There are ten different counseling groups for students to participate.
- Parent Programs- Student Assistance Counselors include parents as collaborative partners in prevention through parent educations programs.
- Referral- Project SUCCESS counselors complete a screening to identify the primary reason for referral. Students that have used or misused substances are provided education to address the behavior and to prevent further use. If this education is ineffective and the behavior is not reversed the student will be referred to appropriate agencies or practitioners in the community. This represents approximately one third (1/3) of students served and ranges between 3,500 and 4,000 students annually. The state does not plan to expend SABG primary prevention funds to any activity designed to determine if a person is in need of treatment or any activity other than primary prevention of substance abuse. The Student Assistance program is only partially funded by SABG and those funds are used for primary prevention only.

- School-wide Awareness Activities- conducted monthly with student participation to influence attitudes and norms about substances and related high risk behaviors.
- The Prevention Education Series- an Alcohol, Tobacco and Other Drug prevention program conducted by a Student Assistance Counselor (SAC) with small groups of students i- Individual and Group Counseling- Student Assistance Counselors conduct time limited individual and group sessions at school with students, There are ten different counseling groups for students to participate.- Parent Programs- Student Assistance Counselors include parents as collaborative partners in prevention through parent educations programs.- Referral- Project SUCCESS counselors complete a screening to identify the primary reason for referral. Students that have used or misused substances are provided education to address the behavior and to prevent further use. If this education is ineffective and the behavior is not reversed the student will be referred to appropriate agencies or practitioners in the community. This represents approximately one third (1/3) of students served and ranges between 3,500 and 4,000 students annually. The state does not plan to expend SABG primary prevention funds to any activity designed to determine if a person needs treatment or any activity other than primary prevention of substance abuse. The Student Assistance program is only partially funded by SABG and those funds are used for primary prevention only. - School-wide Awareness Activities- conducted monthly with student participation to influence attitudes and norms about substances and related high risk behaviors.
Under the recent SOR grant, an opioid module will be added to the Prevention Education Series at all schools and an additional eight schools will receive Student Assistance Services, bringing the total to around 70 middle and high schools receiving Student Assistance Services.

e) Community-Based Processes:

RPTF coalitions organize systemic planning, community team-building, multi-agency coordination/collaboration, community and volunteer training, assessing service and funding. One example of community-based process is monthly municipal coalition meetings are held that include stakeholders across the seven core sectors, behavioral health foci and continuum of care.
o Business
o Education
o Safety
o Medical/health
o Government
o Community/family supports
o Youth and young adults

The focus of the regional coalition meetings is to develop activities, events and to implement evidence-based programs in order to reach the goals of the multi-year regional strategic plan and municipal prevention annual work plans.

f) Environmental:

RPTF coalitions establish/changes to community standards, codes, and attitudes: e.g. school tobacco, alcohol, and other drug policies, product pricing, social norms, and technical assistance to maximize local enforcement. Nearly all of the RPTF coalitions assist development of school policies that prohibit substance use on school property. Coalitions implement tobacco control programs such as retail licensing and other restrictions.
RPTF coalitions assist in the collaboration of municipal police departments as well as the recruitment of underage inspectors for both alcohol and Synar tobacco inspections. The state does not plan to expend SABG primary prevention funds for law enforcement apart from paying for law enforcement officers' time during Synar youth tobacco access inspections.

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

a) If yes, please describe.

BHDDH performs a Request for Proposals (RFP) procurement process. Our prevention providers are required to submit a formal application to request funds. Our technical review team performs an evaluation of the proposal scoring each section ensuring that primary prevention activities are included and that they are a proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles. Our providers are required to perform primary prevention activities that include interventions, occurring prior to the initial onset of a substance use disorder, through reduction or control of factors causing substance abuse, including the reduction of risk factors contributing to substance use. Contract monitors go through monthly invoices to ensure that dollars are spent on allowable costs and use the Mosaix IMPACT(c) data system to look at activities to ensure they are within the scope of their contracted work.

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

BHDDH requires our regional coalitions to perform a Needs Assessment every 3 years. Their implementation plan contains strategies to ensure cultural competency in staffing or sub-contracting and a process to assess cultural relevance and cultural appropriateness of the evidence-based programs being implemented to advance health equity and to help eliminate health disparities.

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

BHDDH requires our providers to have an implementation plan, task and timeline for future ventures, description of how the evidence-based practices would be continued by either internal or external coalition partners.

b) If no, please explain in the box below

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

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

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

I uploaded the RI Evaluation Plan into the Attachments Page.

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

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

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

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

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

- **a)** [x] 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** [x] Heavy use

c) ☑ Binge use

d) ☑ Perception of harm

e) ☑ Disapproval of use

f) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

g) ☐ Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? ◉ Yes ○ No

a) If yes, please explain in the box below.

BHDDH requires our regional coalitions to perform a Needs Assessment every 3 years. Their evaluation plan must ensure that culturally appropriate and relevant measures are being utilized for monitoring and evaluation as well as include a process for monitoring the cultural competence of community level activities to advance health equity and to help eliminate health disparities.

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

BHDDH requires our providers to have an evaluation plan that describes monitoring program activities, including evidence -based programs, sustainability.

b) If no, please explain in the box below.

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

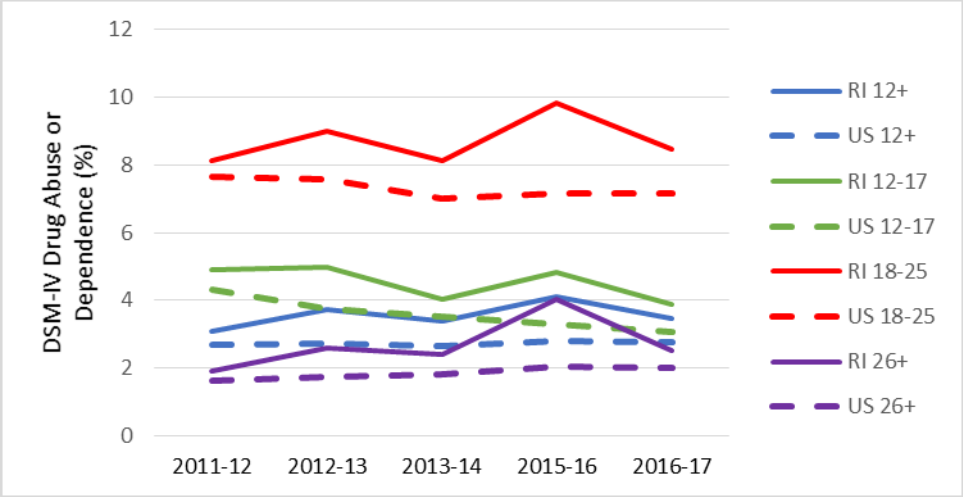
OBJECTIVE: The BHDDH 2019-2024 Strategic Plan contains the following objective related to overdose prevention: By December 2022, 100% of RI communities will sustain at least one activity promoting safer disposal practice previously funded by discretionary grants (Count It, Lock It, Drop media campaign: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

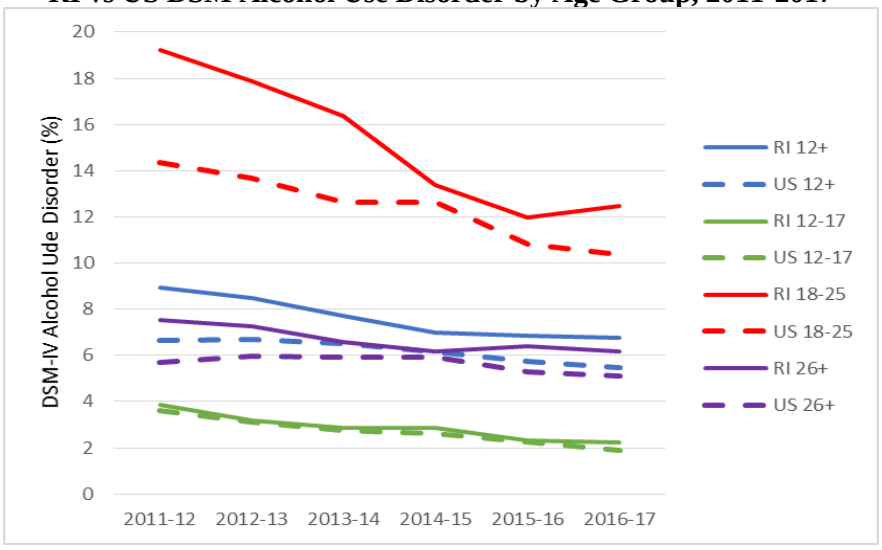
While diagnosis of substance use disorder as defined by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) diagnoses of substance use disorder are potentially changeable with primary prevention strategies, it will take considerably longer than the time frame covered in this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

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



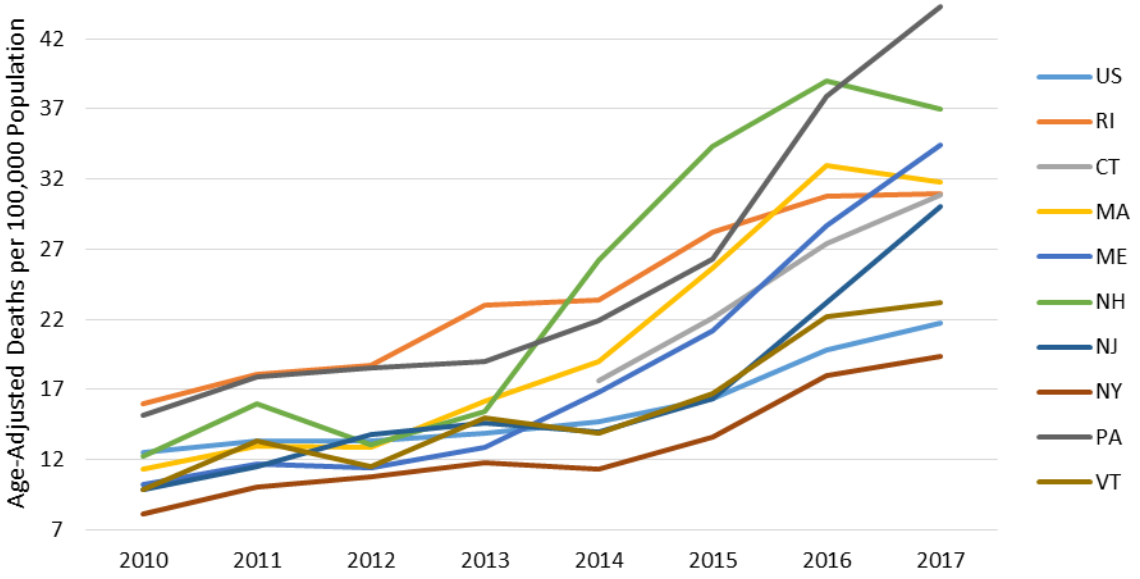
Source: National Survey on Drug Use and Health (NSDUH). **Note:** No data available for 2014-2015.

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



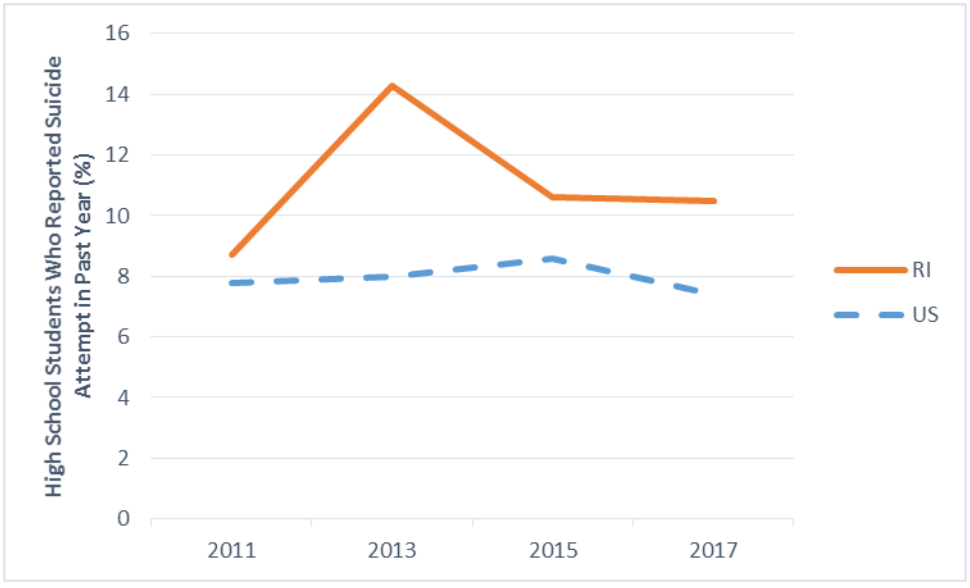
Source: National Survey on Drug Use and Health (NSDUH). ***Note:*** *Indicator name changed from Alcohol Abuse or Dependence to Alcohol Use Disorder in 2014-15.*

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.

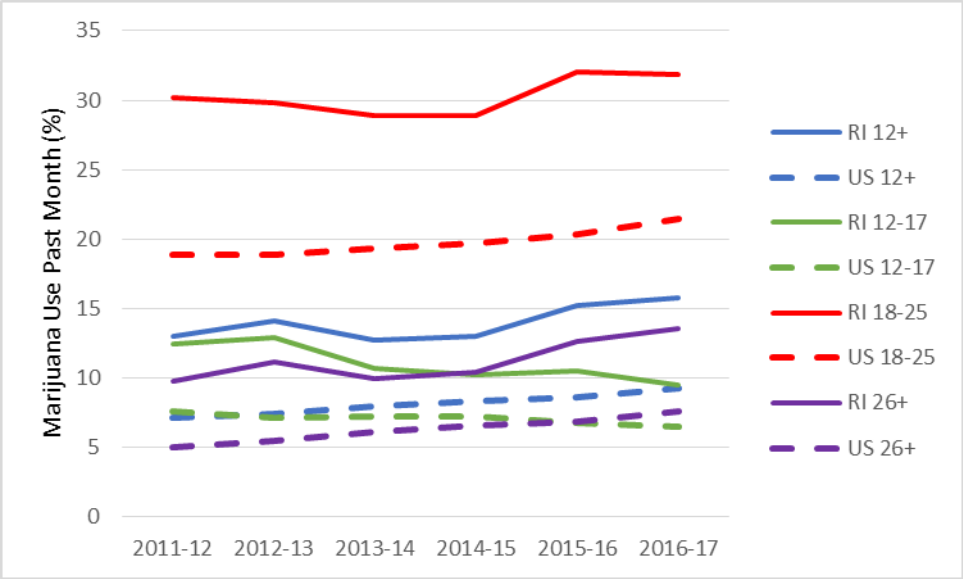
[1] Please note that the 2013 percentages reported in the chart above are believed to be an anomaly based on the RI Department of Health's review of other data for the same time frame

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

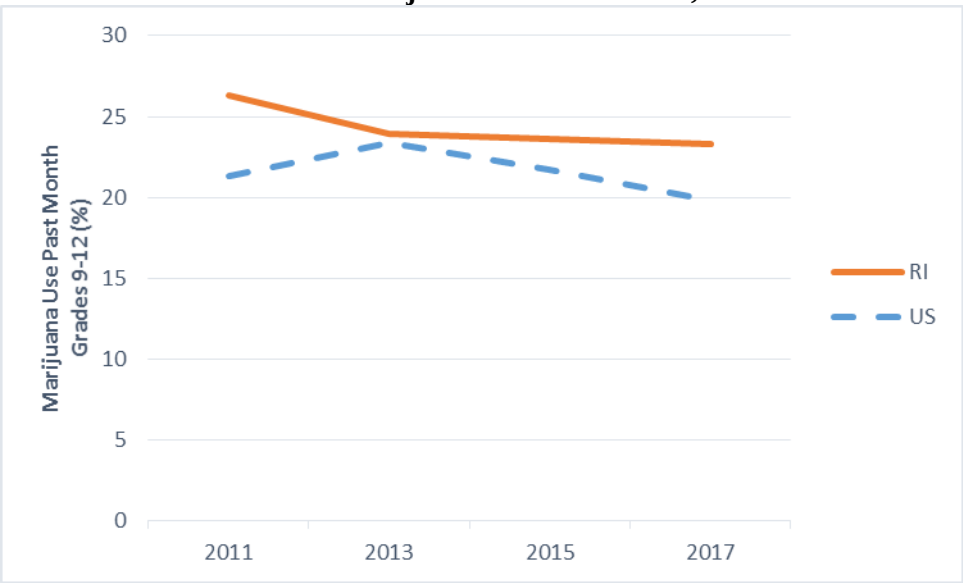


Source: National Survey on Drug Use and Health (NSDUH)

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



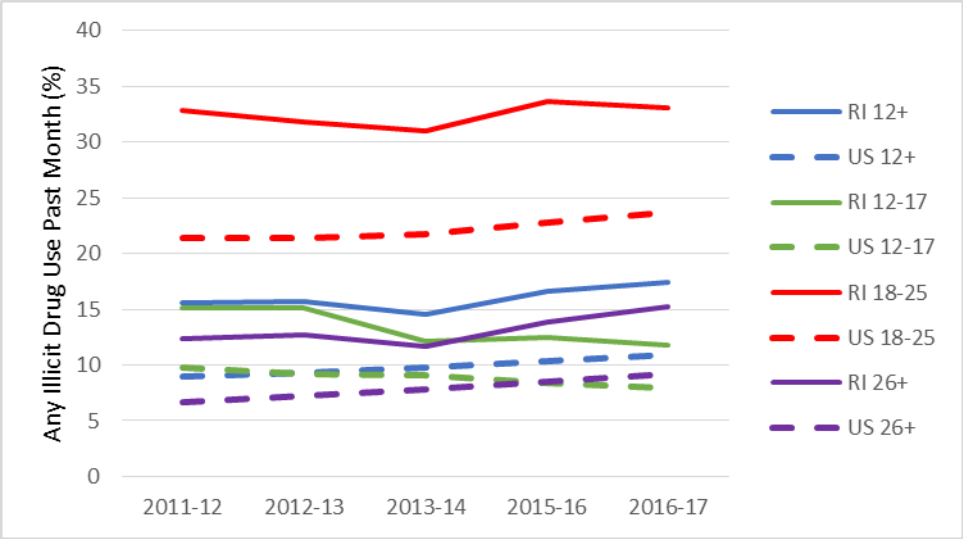
Source: Youth Risk Behavior Survey, Centers for Disease Control

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)

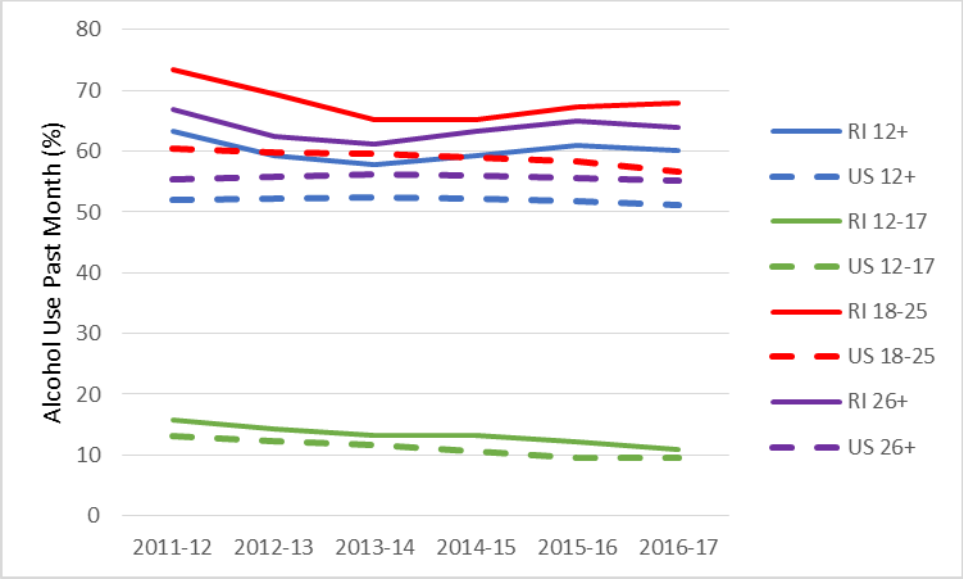
Underage Drinking and Past 30-Day Use Among Young Adults 18-25

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.

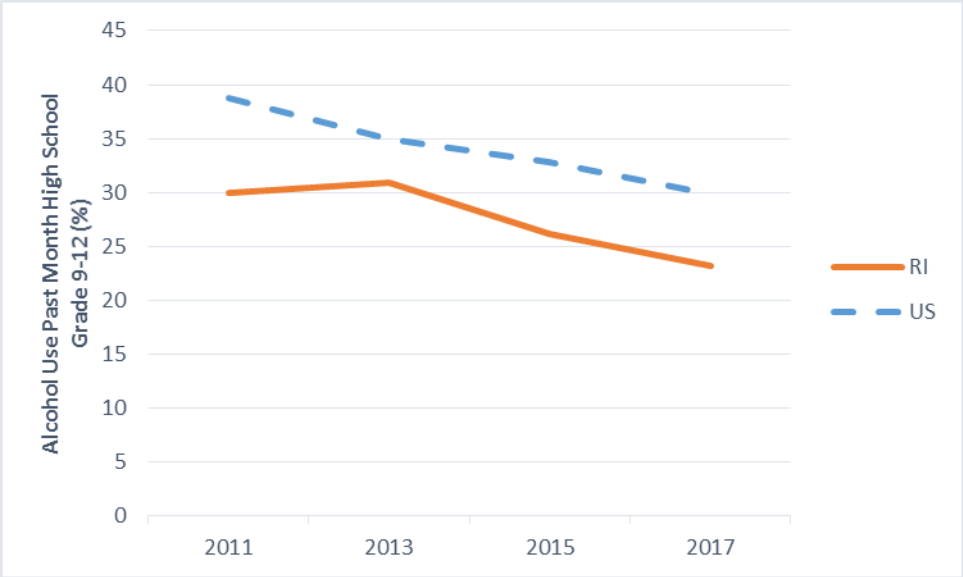
Alcohol Use Past Month by Age Group, 2011-2017



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

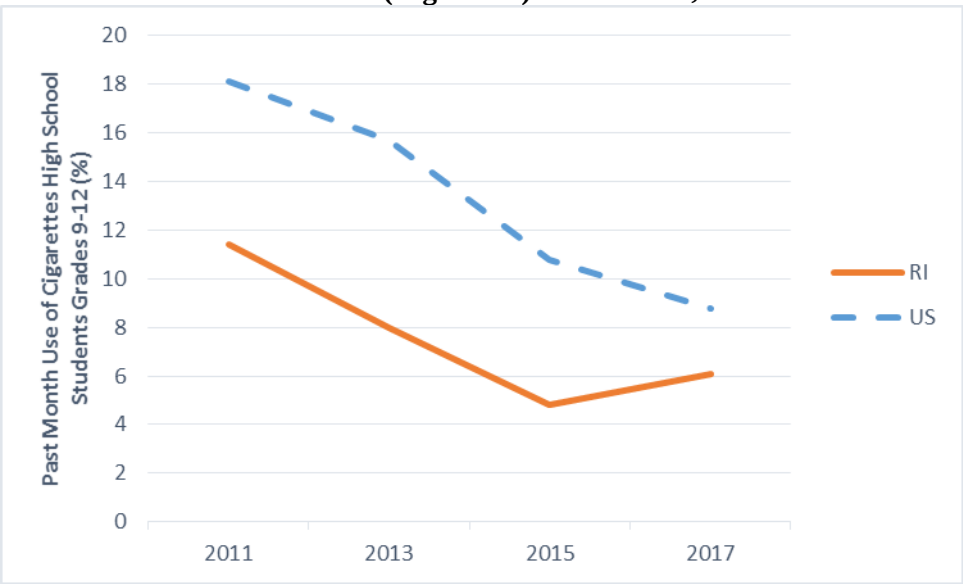
Youth Tobacco Use

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.

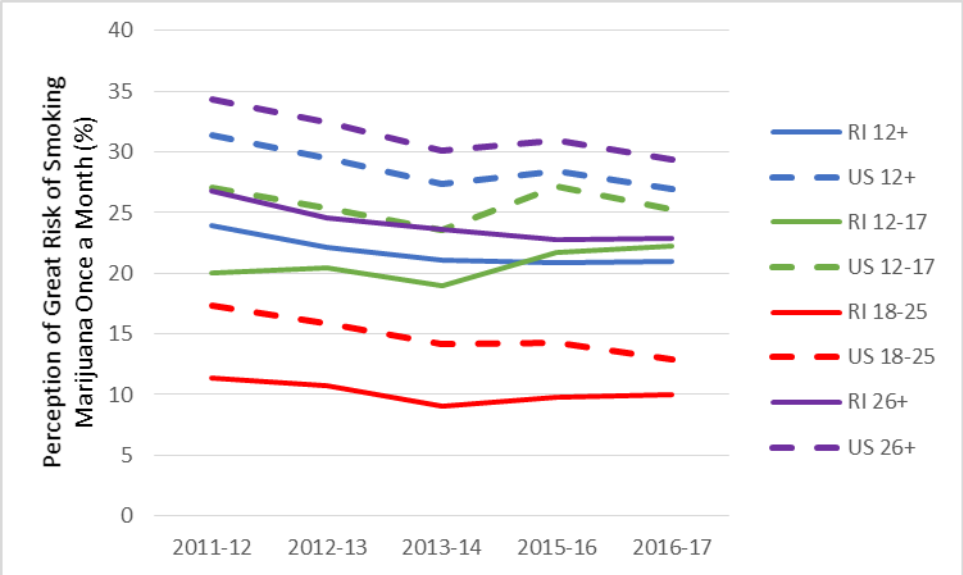
BHDDH provides funds through the Substance Abuse Prevention and Treatment Block Grant to RI communities to implement strategies to address these risk and protective factors. In addition, twenty Rhode Island communities are currently receiving funding through the Partnerships for Success II (PFS II) grant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

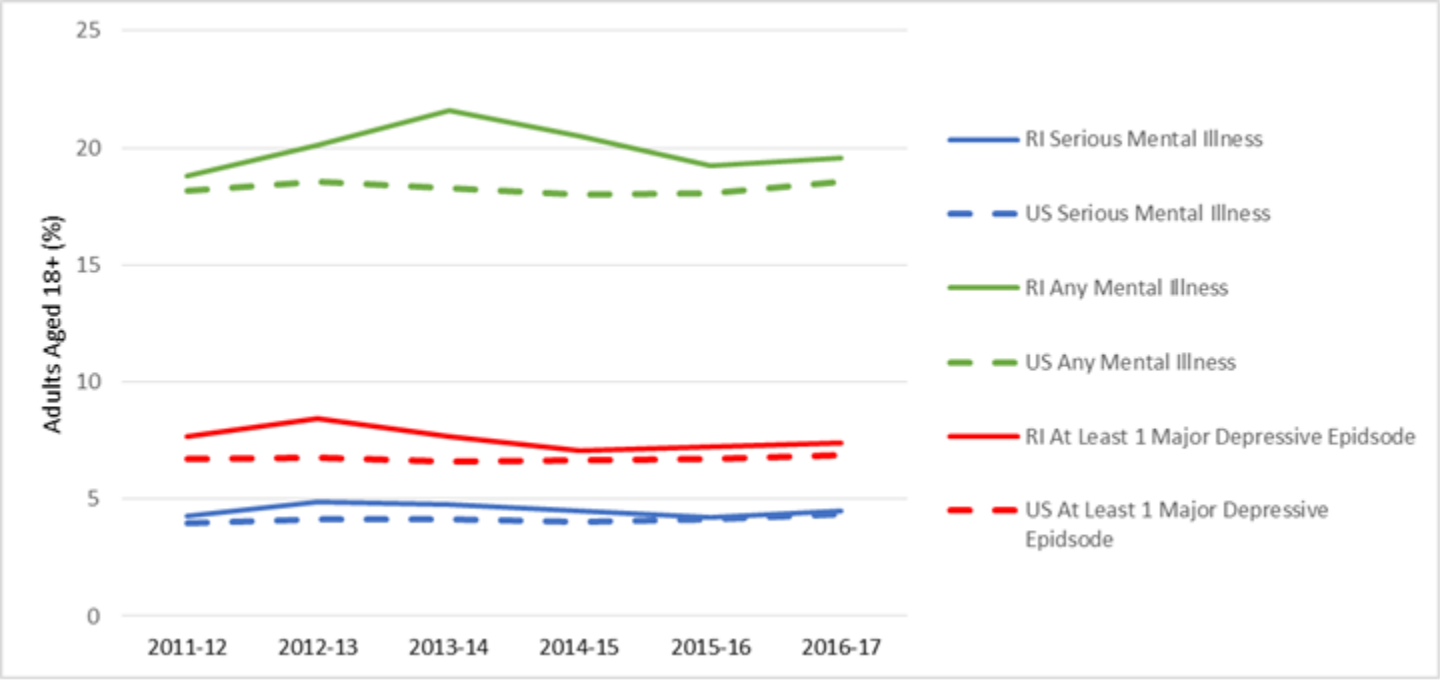
b. Access and Availability of Substances with Age Based or Other Conditional Use Restrictions

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.

Annual Evaluation Report

Prepared for: Behavioral Health, Developmental Disbailities, and Hospitals (BHDDH)

Prepared by: Dorothy Skierkowski-Foster, PHD & Paul Florin, PHD

August 30, 2018

EXECUTIVE SUMMARY

Objective

The purpose of this report is to provide an annual evaluation summary of the work completed by the Community Research and Services Team (CRST) at the the University of Rhode Island (URI) for BHDDH. The CRST holds a cooperative agreement with BHDDH for evaluation of the following three projects included in this report:

1. Regional Prevention Task Forces (RPTF) RFP#7550738
2. Rhode Island Student Assistance Services/Project Success (RFP#7574929)
3. Rhode Island Prevention Resource Center (RIPRC)

Outline

This report contains three sections specific to each component of the evaluation.

Section A contains information specific to evaluation of the *Regional Prevention Task Forces*. Specific tasks completed by the CRST in this domain include:

- Development of evaluation plan conceptualizing implementation of new regional model as an infrastructure intervention (network analysis)
- monitoring of relevant network data in the Mosaix Impact system
- design, administration, analysis and dissemination of results from the annual coalition member survey (see Appendix A-1)
- development of tools to enhance regional evaluation capacity (SMART evaluation guidance document; attendance tracking sheet- See Appendix A-2 and A-3, respectively)
- provision of evaluation TA to regional coalition leaders
- Monitoring of response rates for 2017-2018 administration of Rhode Island Student Survey
- Continued representation at meetings of the SEOW

Section B contains information specific to evaluation of *Rhode Island Student Assistance Services/ Project Success*. Specific tasks completed by the CRST in this domain include:

- Development of evaluation plan for process evaluation of fidelity to the Project Success model, with particular emphasis on adherence to content in the four-module Prevention Education Series
- Development of tools to enhance implementation with fidelity (see Appendix B-1 and B-2 for letter to Student Assistance Counselor Supervisors and Implementation Fidelity guideline handouts, respectively.)
- Monitoring of relevant data in the Mosaix Impact system

COMMUNITY RESEARCH & SERVICES TEAM (CRST) - UNIVERSITY OF RHODE ISLAND

Section C contains information specific to evaluation of the *Rhode Island Prevention Resource Center (RIPRC).* Specific tasks completed by the CRST in this domain include:

- Development of process evaluation using transfer of training model to understand long-term behavioral implications of participation in planned technical assistance and training provided by the RIPRC

SECTION A: REGIONAL PREVENTION TASK FORCES (RPTF)

INFRASTRUCTURE

In accordance with the specific tasks in the scope of work provided to BHDDH, the CRST aims to assess the efficacy of the newly formed RPTF model as a viable delivery system for substance abuse prevention services and mental health promotion. The first year of the evaluation focused on developing an understanding of baseline network characteristics, including ***network connectivity*** and ***network health.***

Network connectivity refers to the number and structure of the connections within the social network. An evaluation of connectivity within and across regions can be useful in determining whether the structure of the network enables efficient sharing of information, ideas, and resources. Information entered by coordinators from the Mosaix Impact system and data obtained from the coalition member survey administered by the CRST were used to answer the following evaluation questions related to baseline network connectivity for all regions:

1. Is network membership across sectors growing and expanding over time?*
2. Is the proportion of members who are active in the network growing?*
3. Are members both bonding and bridging in the network?*

*Information regarding network growth and expansion across sectors is included in Table 1, under the 'Fidelity' and 'Expansion' sub-headings. Overall, regions exhibited some growth in sector representation from January, 2017 (typically little to no outside sector representation) to the present (representation in at least one sector at most RPTF meetings). Some regions began their work in December, 2017, and June, 2018 (Region 1 and 4, respectively). Given the strength of the existing prevention infrastructure in Region 3 (Providence), sector representation remained consistent from the initial stages of the project.

Network health refers to how well a network is functioning. Data evaluating network health were obtained from the coalition member survey administered by the CRST in April - June, 2018. Evaluation questions related to network health include:

1. Are regional coordinators participating and exercising leadership as they are able to?
2. What is the level of trust among members in the network?
3. What are the power relationships within the network and how are decisions made?

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Region 1: Southern Providence (Cranston, Foster, Glocester, Scituate, North Providence, Smithfield, Johnston)

Network health. Region 1 did not participate in the Coalition Member Survey at the time of administration due to the recency of its formation. Region 1 will complete the survey between December, 2018, and January, 2019.

Region 2: Northern Providence/Blackstone Valley (Burrillville, Woonsocket, Cumberland, Lincoln, Pawtucket, North Smithfield, Central Falls)

Network health. Coalition member survey was administered but the number of responders was lower than the minimum required (five) to summarize data into a Coalition member survey report.

Region 3: Providence

Network health. Coalition member survey report prepared based upon 13 respondents. Twelve (93%) of respondents were "clear" or "very clear" on various aspects of the Regional coalition such as *major objectives*; *governance structure*; *risk and protective factor framework being used*. Leadership and decision making is perceived quite positively by members. For example, twelve responders (93%) "agreed" or "strongly agreed" that *the group has a feeling of cohesiveness and team spirit* and 13 respondents (100%) that *communication in the group is open and honest.* In terms of an area for potential improvement, 6 respondents (46%) "neither agreed nor disagreed" that the *group needs more formalization and structure* and one respondent (8%) agreed. Respondents perceived that "partnership synergy" (defined as "combining the different perspectives, knowledge and skills of the group of people and organizations represented") was strong. For example, 11 respondents (85%) "agreed" or "strongly agreed" that *The RPTF has developed a common language for communication among diverse partners* and *The RPTF has developed common goals that are understood and supported by all partners.* Moreover, 9 respondents (70%) said the involvement of different kinds of partners enabled the RPTF to *plan activities that connect multiple services, programs or systems* "a lot" and 12 respondents (93%) said the involvement of different kinds of partners led *"*some" or "a lot" *to new and better ways of thinking about how the RPTF can achieve its goals*.

Region 4: Kent County

Network health. Region 4 did not participate in the Coalition Member Survey at the time of administration because it was not yet in existence. Region 4 will complete the survey after hosting RPTF meetings for a minimum of six months.

Region 5: East Bay (East Providence, Barrington, Warren, Bristol)

Network health. Coalition member survey report prepared based upon 13 respondents. Eight to ten (66% - 93%) of respondents were "clear" or "very clear" on various aspects of the Regional coalition such as *major objectives*; *governance structure*; *risk and protective factor framework being used*. Leadership and decision making is perceived positively by members. For example, ten responders (83%) "strongly agreed" that *the group has a feeling of cohesiveness and team spirit* and 9 respondents (75%) that *communication in the group is open and honest.* In terms of an area for potential improvement, only slightly more than half of the respondents (7 or 58%) "agreed" that *everyone is involved in discussions, not just a few.* Respondents perceived that "partnership synergy" (defined as "combining the different perspectives, knowledge and skills of the group of people and

organizations represented") was moderate. For example, 7 respondents (58%), only slightly more than half, "agreed" or "strongly agreed" that *the RPTF has developed a common language for communication among diverse partners* and *the RPTF has combined the perspectives, resources, and skills of partners.* However, in more specific questions respondents endorsed stronger evidence for outcomes produced by "partnership synergy." For example,10 (83%) said the involvement of different kinds of partners enabled the RPTF to *plan activities that connect multiple services, programs or systems* "a lot" and 10 respondents (83%) said the involvement of different kinds of partners led "some" or "a lot" *to new and better ways of thinking about how the RPTF can achieve its goals*.

Region 6: Newport County (Portsmouth, Tiverton, Little Compton, Jamestown, Middletown, Newport)

Network health. Coalition member survey report prepared based upon 6 respondents. Six (100%) of respondents were "clear" or "very clear" on various aspects of the Regional coalition such as *major objectives*; *your own role in the RPTF (i.e., who you are representing)* and *the common language (e.g., definition of prevention being used.)* Leadership and decision making is perceived quite positively by members. For example, six responders (100%) "agreed" or "strongly agreed" that *the group has a feeling of cohesiveness;* that *communication in the group is open and honest;* and that *the members have real decision-making control.* In terms of an area for potential improvement, 2 respondents (33%) "agreed" that the *group needs more formalization and structure* and an additional 2 respondents (33%) "neither agreed nor disagreed". Respondents perceived that "partnership synergy" (defined as "combining the different perspectives, knowledge and skills of the group of people and organizations represented") was strong. For example, 5 respondents (83%) "agreed" or "strongly agreed" that *the RPTF has developed a common language for communication among diverse partners* and all six respondents (100%) that *the RPTF has developed common goals that are understood and supported by all partners.* Moreover, 5 respondents (83%) said the involvement of different kinds of partners enabled the RPTF to *plan activities that connect multiple services, programs or systems* "some" or "a lot" and 6 respondents (100%) said the involvement of different kinds of partners led "some" or "a lot" *to new and better ways of thinking about how the RPTF can achieve its goals*.

Region 7: South County (North Kingstown, Narragansett, South Kingstown, Hopkinton, Richmond, Charlestown, Westerly, New Shoreham)

Network health. Coalition member survey report prepared based upon 7 respondents. Six (85%) of respondents were "clear" or "very clear" on various aspects of the Regional coalition such as *major objectives*; *your own role in the RPTF (i.e., who you are representing)* and *the common language (e.g., definition of prevention being used.)* One potential area for improvement here is that 2 respondents (28%) were "unclear" about *the timelines for RPTF product (aka "deliverables') completion.* Leadership and decision making is perceived as mixed by the respondents. For example, although 4 responders (72%) "agreed" or "strongly agreed" that *the group has a feeling of cohesiveness,* 2 (29%) responded "neither agree nor disagree". Similarly, although 4 respondents (72%) "agreed" or "strongly agreed" that *the members have real decision-making control,* 3 (43%) responded "neither agree nor disagree". In another area for potential improvement, 1 respondent (14%) "strongly agreed" and 1 (14%) "agreed" that the *group needs more formalization and structure* and an additional 1 respondent (14%) "neither agreed nor disagreed". Respondents perceived that "partnership synergy" (defined as "combining the

different perspectives, knowledge and skills of the group of people and organizations represented") was moderate. For example, 5 respondents (68%) "agreed" or "strongly agreed" that *the RPTF has developed common goals that are understood and supported by all partners* and *the RPTF has combined the perspectives, resources and skills of partners.* However, in more specific questions, respondents endorsed stronger evidence for outcomes produced by "partnership synergy." For example, 7 (100%) said the involvement of different kinds of partners enabled the RPTF "some" *or* "a lot" *to plan activities that connect multiple services, programs or systems* and the involvement of different kinds of partners led "some" *or* "a lot" *to new and better ways of thinking about how the RPTF can achieve its goals.*

FIDELITY

In addition to evaluating the efficacy of the new regional model to deliver prevention and mental health promotion services, the CRST also aims to assess fidelity to the model proposed in the RFP.

Expansion

Process data regarding expansion across the six core sectors described in the RFP were obtained from the Impact Mosaix system for each region. **Table 1** demonstrates sector representation at RPTF meetings for each region from the beginning of the project. Month 1 corresponds to the first meeting held by the RPTF and is considered baseline. Cell values represent the number of individuals present from each sector at every RPTF meeting. For regions that started on January 1, 2017, Month 1 corresponds with this date, and Month 19 corresponds with July, 2018. In a few instances, regions did not enter data corresponding with a RPTF meeting every month. In other instances, it is unclear from the information in Mosaix how sectors are represented at monthly meetings.

TABLE 1: NETWORK CONNECTIVITY/EXPANSION

Region	Month Since First RPTF Meeting																		
Sector	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Business																			
1												0	0	0	0	0	2	2	2
2	0	0	0	0	1	1	0	1	1	1	1	1	1	1	0	0	0	0	0
3	0	0	1	1	1	0	0	0	1	1	0	0	1	0	0	0	1	0	0
4																		0	0
5	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2
Education																			
1												0	0	0	0	0	3	1	1
2	0	0	0	0	1	1	0	1	1	1	0	0	1	0	0	1	0	0	0
3	1	2	1	1	2	0	0	0	2	1	0	0	1	1	0	2	1	2	0
4																		0	0
5	0	0	0	0	2	0	0	0	1	1	2	2	0	2	1	1	1	0	0

TABLE 1: NETWORK CONNECTIVITY/EXPANSION

Region	Month Since First RPTF Meeting																		
Sector	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	1	0	0
Safety																			
1												0	0	0	0	0	3	2	1
2	0	0	0	0	1	1	0	1	0	1	1	1	0	0	0	0	0	0	0
3	1	1	0	0	1	2	0	0	2	0	0	0	0	0	0	0	0	0	0
4																		0	0
5	0	0	0	0	0	1	1	0	1	0	0	0	0	0	0	0	0	0	0
6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Medical																			
1												0	0	0	0	0	4	2	3
2	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0
3	1	1	3	1	2	2	0	1	4	4	0	0	4	3	0	5	3	3	3
4																		0	0
5	0	0	0	0	1	2	1	0	1	1	1	0	1	0	0	1	2	0	0
6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	3	4	2	3
Government																			
1												0	0	0	0	0	1	1	1
2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3	1	1	1	1	1	1	0	0	0	1	0	0	0	1	0	1	1	1	1
4																		0	9
5	0	0	0	0	0	0	0	0	1	1	1	2	0	0	1	1	0	0	0
6	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0

TABLE 1: NETWORK CONNECTIVITY/EXPANSION

Region	Month Since First RPTF Meeting																		
Sector	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Community/ Family																			
1												0	0	0	0	0	1	0	2
2	0	0	0	0	3	5	0	6	5	5	5	5	5	4	0	2	0	0	0
3	2	3	2	3	3	3	0	2	1	2	0	0	2	2	0	2	2	2	2
4																		0	0
5	0	0	0	0	1	1	1	0	0	1	1	2	1	1	2	2	1	0	0
6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7	0	0	0	0	0	0	0	0	0	0	1	0	0	0	4	1	0	1	1

Region 1: Southern Providence (Cranston, Foster, Glocester, Scituate, North Providence, Smithfield, Johnston)

Region 1 began hosting RPTF meetings in December, 2017. For the first five months of the RPTF in Region 1, no sector representation was noted at any RPTF meetings. After month 6, Region 1 was represented by all six sectors other than Community/Family at every subsequent meeting (three total).

Region 2: Northern Providence/Blackstone Valley (Burrillville, Woonsocket, Cumberland, Lincoln, Pawtucket, North Smithfield, Central Falls)

Region 2 began hosting RPTF meetings in January, 2017. For the first four months of the RPTF in Region 2, no sector representation was noted at any RPTF meetings. After month 5, Region 2 RPTF meetings were attended most consistently by Community/Family (10 meetings), Business (9 meetings), Education (7 meetings), and Safety (6 meetings) sector representatives. Little to no attendance is noted by Medical (2 meetings) and Government (0 meetings) sector representatives.

Region 3: Providence

Region 3 began hosting RPTF meetings in January, 2017. Since January, 2017, RPTF meetings in Providence were attended by representatives from all six sectors, in descending order of attendance: Community/Medical (15 meetings), Medical (15 meetings), Education (12 meetings), Government (12 meetings), Business (7 meetings), and Safety (5 meetings).

Region 4: Kent County

Region 4 began hosting RPTF meetings in June, 2018. Primary tasks since that time have focused on building regional coalition capacity and preparing a strategic plan for Region 4.

Region 5: East Bay (East Providence, Barrington, Warren, Bristol)

Region 5 began hosting RPTF meetings in January, 2017. Since January, 2017, RPTF meetings in Region 5 were attended by representatives from all six sectors, in descending order of attendance: Community/Medical (11 meetings), Education (9 meetings), Medicine (9 meetings), Government (6 meetings), Safety (3 meetings), and Business (1 meeting).

Region 6: Newport County (Portsmouth, Tiverton, Little Compton, Jamestown, Middletown, Newport)

Region 6 began hosting RPTF meetings in January, 2017. Since January, 2017, RPTF meetings in Region 6 were attended by a representative from the Government sector on one occasion only. No other sector representatives were recorded at RPTF meetings in Region 6 since January, 2017. It is possible this may be due to a lack of understanding in how to report sector representation in the Mosaix system or in RPTF meeting minute notes. The CRST has created an attendance tracking sheet to properly document sector representation at all future RPTF meetings across regions.

Region 7: South County (North Kingstown, Narragansett, South Kingstown, Hopkinton, Richmond, Charlestown, Westerly, New Shoreham)

Region 7 began hosting RPTF meetings in January, 2017. Since January, 2017, RPTF meetings in Region 7 were attended by representatives from all six sectors, in descending order of attendance: Community/Medical (5 meetings), Medical (5 meetings), Education (3 meetings), Business (2 meetings), Safety (1 meeting), and Government (1 meeting). No sector representation was noted until the 11th month in which RPTF meetings were held (November, 2017).

Implications: The CRST developed an attendance tracker to assist regions with documenting sector representation at all future meetings. In many instances, the data that are entered in Mosaix are incomplete or inaccurate. The CRST is amenable to providing regions with TA regarding network data collection efforts moving forward.

Rhode Island Student Survey

In addition, regions were required to participate in the Rhode Island Student Survey (RISS). For the 2017/2018 administration of the RISS, 80% of districts within each region were required to participate in the survey with a minimum of two grades.

Table 2 demonstrates the number of schools in each region who participated in the RISS, as well as response rates by grade level, using October enrollment data from RIDE. School names highlighted in GREEN represent schools at which the RISS was administered. Cell values highlighted in RED represent grade levels for which the

response rate was below the 60% threshold collaboratively agreed upon by BHDDH, the SEOW, and the CRST for reporting relevant statistics.

TABLE 2: PARTICIPATION IN RISS, BY REGION, WITH NUMBER OF COMPLETED SURVEYS (N) AND RESPONSE RATE (%), BY GRADE LEVEL

Region	Grade Level													
	6		7		8		9		10		11		12	
	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%
1: Southern Providence														
Cranston														
Oak Lawn School														
Cranston Early Learning Center														
Daniel D. Waterman School														
Chester W. Barrows School														
Cranston High School East	-	-	-	-	-	-	447	(243) 54.4	418	(220) 52.6	422	(1) NA	371	(1) NA
Hugh B. Bain Middle School	185	(6) 3.2	204	(8) 3.9	219	(106) 48.4	-	-	-	-	-	-	-	-
William R. Dutemple School														
Edward S. Rhodes School														
Eden Park School														
Gladstone Street School														
Stadium School														
Woodridge School														
Garden City School														
Park View Middle School	210	NA	234	NA	229	(209) 91.3	-	-	-	-	-	-	-	-
George J. Peters School														

TABLE 2: PARTICIPATION IN RISS, BY REGION, WITH NUMBER OF COMPLETED SURVEYS (N) AND RESPONSE RATE (%), BY GRADE LEVEL

Region	Grade Level													
	6		7		8		9		10		11		12	
	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%
Arlington School														
Cranston High School West	-	-	-	-	-	-	319	(214) 67.1	356	(285) 80.1	391	(1) NA	348	(5) 1.4
Stone Hill School														
Glen Hills School														
Western Hills Middle School	266	NA	254	NA	259	(226) 87.3	-	-	-	-	-	-	-	-
Edgewood Highland School														
NEL/CPS Construction Career Academy														
Orchard Farms Elementary School														
Hope Highlands Middle School	124	NA	132	NA	142	(134) 94.4	-	-	-	-	-	-	-	-
Foster/ Glocester														
Ponaganset Middle School	169	NA	170	NA	170	(149) 87.6	-	-	-	-	-	-	-	-
Ponaganset High School	-	-	-	-	-	-	202	(169) 83.7	175	(137) 78.3	192	(132) 68.8	174	(122) 70.1
Captain Isaac Paine Elementary School														
Fogarty Memorial School														
West Glocester Elementary														
Scituate														
Hope Elementary School														

TABLE 2: PARTICIPATION IN RISS, BY REGION, WITH NUMBER OF COMPLETED SURVEYS (N) AND RESPONSE RATE (%), BY GRADE LEVEL

Region	Grade Level													
	6		7		8		9		10		11		12	
	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%
Clayville Elementary School														
Scituate High School	-	-	-	-	-	-	102	(86) 84.3	95	(81) 85.3	103	(85) 82.5	113	77 (68.1)
Scituate Middle School	90	(80) 88.9	119	(95) 79.8	117	(105) 89.7	-	-	-	-	-	-	-	-
North Scituate Elementary School														
North Providence														
Marieville Elementary School														
North Providence High School														
Stephen Olney School														
James L. McGuire School														
Dr. Joseph A Whelan Elementary School														
Centredale School														
Greystone School														
Dr. Edward A. Ricci Middle School														
Birchwood Middle School														
Smithfield														
William Winsor School														
Old County Road School														
Anna M. McCabe School														

TABLE 2: PARTICIPATION IN RISS, BY REGION, WITH NUMBER OF COMPLETED SURVEYS (N) AND RESPONSE RATE (%), BY GRADE LEVEL

Region	Grade Level													
	6		7		8		9		10		11		12	
	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%
Smithfield Senior High School	-	-	-	-	-	-	161	(68) 42.2	198	(96) 49	184	(1) NA	161	(0) NA
Raymond C. LaPerche School														
Vincent J. Gallagher Middle School	192	NA	208	(189) 90.9	187	(167) 89.3	-	-	-	-	-	-	-	-
Johnston														
Thornton School														
Brown Avenue School														
Sarah Dyer Barnes School														
Winsor Hill School														
Graniteville School														
Nicholas A. Ferri Middle School	269	NA	254	(208) 81.9	250	(209) 83.6	-	-	-	-	-	-	-	-
Johnston Senior High School	-	-	-	-	-	-	251	(171) 68.1	242	(153) 63.2	201	(101) 50.2	195	(3) 1.5
Early Childhood Center														
2: Northern Providence/ Blackstone Valley														
Burrillville														
Burrillville Middle School	177	NA	177	NA	183	(156) 85.2	-	-	-	-	-	-	-	-
Steere Farm Elementary School														
William L. Callahan School														
Austin T. Levy School														

TABLE 2: PARTICIPATION IN RISS, BY REGION, WITH NUMBER OF COMPLETED SURVEYS (N) AND RESPONSE RATE (%), BY GRADE LEVEL

Region	Grade Level													
	6		7		8		9		10		11		12	
	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%
Burrillville High School	-	-	-	-	-	-	182	(138) 75.8	197	(154) 78.2	211	(150) 71.1	174	(117) 67.2
Woonsocket														
Harris School														
Governor Aram J. Pothier School														
Citizens Memorial School														
Bernon Heights School														
Globe Park School														
Leo A. Savoie School														
Woonsocket High School	-	-	-	-	-	-	458	(289) 63.1	418	(261) 62.4	365	(183) 50.1	331	(166) 50.2
Kevin K. Coleman Elementary School														
Woonsocket Middle School at Hamlet	219	(260) 56.9	231	(320) 76.9	213	(297) 72.6	-	-	-	-	-	-	-	-
Woonsocket Middle School at Villa Nova	238		185		196		-	-	-	-	-	-	-	-
Cumberland														
B.F. Norton Elementary School														
Garvin Memorial School														
Community School														
John J. McLaughlin Cumberland Hill School														
Ashton School														

TABLE 2: PARTICIPATION IN RISS, BY REGION, WITH NUMBER OF COMPLETED SURVEYS (N) AND RESPONSE RATE (%), BY GRADE LEVEL

Region	Grade Level													
	6		7		8		9		10		11		12	
	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%
Cumberland High School	-	-	-	-	-	-	397	(281) 70.8	360	(5) 1.4	375	(5) 1.3	256	(1) NA
Joseph L. McCourt Middle School	150	NA	156	NA	140	(126) 90	-	-	-	-	-	-	-	-
North Cumberland Middle School	194	NA	214	(1) NA	246	(183) 74.4	-	-	-	-	-	-	-	-
Cumberland Preschool Center														
Lincoln														
Lonsdale Elementary School														
Lincoln Central Elementary School														
Lincoln Senior High School														
Saylesville Elementary School														
Northern Lincoln Elementary School														
Lincoln Middle School														
Pawtucket														
Joseph Jenks Middle School	209	NA	215	NA	190	(118) 62.1	-	-	-	-	-	-	-	-
William E Tolman Senior High School	-	-	-	-	-	-								
Samuel Slater Middle School	243	(12) 4.9	270	(9) 3.3	267	(156) 58.4	-	-	-	-	-	-	-	-
Lyman B. Goff Middle School	234	NA	269	NA	245	(210) 85.7	-	-	-	-	-	-	-	-

TABLE 2: PARTICIPATION IN RISS, BY REGION, WITH NUMBER OF COMPLETED SURVEYS (N) AND RESPONSE RATE (%), BY GRADE LEVEL

Region	Grade Level													
	6		7		8		9		10		11		12	
	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%
Jacqueline M. Walsh School for the Performing and														
Potter-Burns School														
Nathanael Greene School														
Fallon Memorial School														
Flora S. Curtis Memorial School														
Curvin-McCabe School														
Blackstone Academy Charter School														
Charles E. Shea High School														
Henry J. Winters School														
Elizabeth Baldwin School														
M. Virginia Cunningham School														
Agnes E. Little School														
Francis J. Varieur School														
Pawtucket Public Schools														
North Smithfield														

TABLE 2: PARTICIPATION IN RISS, BY REGION, WITH NUMBER OF COMPLETED SURVEYS (N) AND RESPONSE RATE (%), BY GRADE LEVEL

Region	Grade Level													
	6		7		8		9		10		11		12	
	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%
Dr. Harry L. Halliwell Memorial School														
North Smithfield High School														
North Smithfield Middle School														
North Smithfield Elementary School														
Central Falls														
Ella Risk School														
Capt. G. Harold Hunt School														
Veterans Memorial Elementary														
Central Falls Senior High School														
Dr. Earl F. Calcutt Middle School														
Margaret I. Robertson School														
3: Providence**	** Note: Providence did not participate in RISS; administers the YES instead													
Leviton Dual Language School														
Frank D. Spaziano Elementary School Annex														
Dr. Jorge Alvarez High School														
Asa Messer Elementary School														
Alan Shawn Feinstein Elementary at Broad Street														

TABLE 2: PARTICIPATION IN RISS, BY REGION, WITH NUMBER OF COMPLETED SURVEYS (N) AND RESPONSE RATE (%), BY GRADE LEVEL

Region	Grade Level													
	6		7		8		9		10		11		12	
	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%
Alfred Lima, Sr. Elementary School														
Charles N. Fortes Elementary School														
Webster Avenue School														
Veazie Street School														
Frank D. Spaziano Elementary School														
George J. West Elementary School														
Esek Hopkins Middle School														
Robert F. Kennedy Elementary School														
Central High School														
Carl G. Lauro Elementary School														
Reservoir Avenue School														
Nathan Bishop Middle School														
Gilbert Stuart Middle School														
Nathanael Greene Middle School														
Roger Williams Middle School														
Hope High School														
Mount Pleasant High School														
Vartan Gregorian Elementary School														

TABLE 2: PARTICIPATION IN RISS, BY REGION, WITH NUMBER OF COMPLETED SURVEYS (N) AND RESPONSE RATE (%), BY GRADE LEVEL

Region	Grade Level													
	6		7		8		9		10		11		12	
	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%
William D'Abate Elementary School														
Robert L Bailey IV, Elementary School														
Lillian Feinstein Elementary, Sackett Street														
Mary E. Fogarty Elementary School														
Harry Kizirian Elementary School														
The Sgt. Cornel Young, Jr & Charlotte Woods Elemen														
Dr. Martin Luther King, Jr. Elementary School														
Classical High School														
Pleasant View School														
Times2 Academy														
Academy for Career Exploration (ACES)														
Anthony Carnevale Elementary School														
Governor Christopher DelSesto Middle School														
E-Cubed Academy														
William B. Cooley, Sr. High School and the Provide														
Providence Career and Technical Academy														

TABLE 2: PARTICIPATION IN RISS, BY REGION, WITH NUMBER OF COMPLETED SURVEYS (N) AND RESPONSE RATE (%), BY GRADE LEVEL

Region	Grade Level													
	6		7		8		9		10		11		12	
	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%
West Broadway Middle School														
360 High School														
Evolutions High School														
5: East Bay														
East Providence														
Edward R. Martin Middle School	209	(0) NA	256	(0) NA	234	(189) 80.8	-	-	-	-	-	-	-	-
James R. D. Oldham School														
East Providence High School	-	-	-	-	-	-	427	(281) 65.8	361	(216) 59.8	395	(219) 55.4	334	(166) 49.7
Kent Heights School														
Alice M. Waddington School														
Agnes B. Hennessey School														
Emma G. Whiteknact School														
Riverside Middle School	205	(1) NA	156	NA	138	(122) 88.4	-	-	-	-	-	-	-	-
Silver Spring School														
Orlo Avenue School														
Myron J. Francis Elementary School														
Barrington														
Primrose Hill School														
Nayatt School														

TABLE 2: PARTICIPATION IN RISS, BY REGION, WITH NUMBER OF COMPLETED SURVEYS (N) AND RESPONSE RATE (%), BY GRADE LEVEL

Region	Grade Level													
	6		7		8		9		10		11		12	
	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%
Hampden Meadows School														
Barrington High School	-	-	-	-	-	-	281	(225) 80.1	312	(233) 74.7	254	(180) 70.9	297	(186) 62.6
Barrington Middle School	261	(227) 87	274	(200) 73	247	(218) 88.3	-	-	-	-	-	-	-	-
Sowams Elementary School														
Bristol/ Warren														
Guiteras School														
Colt Andrews School														
Rockwell School														
Mt. Hope High School	-	-	-	-	-	-	257	NA	218	(1) NA	241	(171) 71	221	(122) 55.2
Kickemuit Middle School														
Hugh Cole School														
6: Newport														
Portsmouth														
Howard Hathaway School														
Portsmouth High School	-	-	-	-	-	-	229	(140) 61.1	257	(177) 68.9	206	(143) 69.4	196	(118) 60.2
Melville Elementary School														
Portsmouth Middle School	174	(130) 74.7	193	(171) 88.6	188	(155) 82.4	-	-	-	-	-	-	-	-
Little Compton														

TABLE 2: PARTICIPATION IN RISS, BY REGION, WITH NUMBER OF COMPLETED SURVEYS (N) AND RESPONSE RATE (%), BY GRADE LEVEL

Region	Grade Level													
	6		7		8		9		10		11		12	
	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%
Wilbur and McMahon Schools	27	NA	29	(12) 41.4	33	(18) 54.5	-	-	-	-	-	-	-	-
Jamestown														
Jamestown School-Lawn														
Jamestown School-Melrose														
Tiverton														
Walter E. Ranger School														
Fort Barton School														
Pocasset School														
Tiverton High School	-	-	-	-	-	-	124	(88) 71	138	(93) 67.4	116	(73) 62.9	138	(57) 41.3
Tiverton Middle School	138	(1) NA	136	(116) 85.3	157	(133) 84.7	-	-	-	-	-	-	-	-
Middletown														
Aquidneck School														
Forest Avenue School														
Middletown High School	-	-	-	-	-	-	133	(96) 71.2	190	(110) 57.9	139	(90) 64.7	128	(36) 28.1
Joseph H. Gaudet School	181	NA	166	(137) 82.5	177	(158) 89.3	-	-	-	-	-	-	-	-
Joseph H. Gaudet Learning Academy														
Newport														
Frank E. Thompson Middle School	140	(1) NA	151	(110) 72.8	144	(53) 36.8	-	-	-	-	-	-	-	-

TABLE 2: PARTICIPATION IN RISS, BY REGION, WITH NUMBER OF COMPLETED SURVEYS (N) AND RESPONSE RATE (%), BY GRADE LEVEL

Region	Grade Level													
	6		7		8		9		10		11		12	
	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%
Claiborne Pell Elementary School														
Rogers High School	-	-	-	-	-	-	208	(103) 49.5	154	(98) 63.6	152	(74) 48.7	152	(69) 45.4
The Pell Annex @ John F. Kennedy School														
7: South County														
North Kingstown														
Wickford Middle School	119	(1) NA	128	(1) NA	142	(133) 93.6	-	-	-	-	-	-	-	-
North Kingstown Senior High School	-	-	-	-	-	-	364	(306) 84.1	377	(292) 77.5	322	(171) 53.1	345	(6) 1.7
Fishing Cove Elementary School														
Forest Park Elementary School														
Hamilton Elementary School														
Davisville Middle School	155	NA	191	NA	180	(167) 92.8	-	-	-	-	-	-	-	-
Suzanne M. Henseler Quidnessett Elementary School														
Stony Lane Elementary School														
Narragansett														
Narragansett Elementary School														
Narragansett Pier School	112	(1) NA	106	(101) 95.3	123	(107) 87	-	-	-	-	-	-	-	-

TABLE 2: PARTICIPATION IN RISS, BY REGION, WITH NUMBER OF COMPLETED SURVEYS (N) AND RESPONSE RATE (%), BY GRADE LEVEL

Region	Grade Level													
	6		7		8		9		10		11		12	
	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%
Narragansett High School	-	-	-	-	-	-	99	(81) 81.8	95	(81) 85.3	115	(70) 60.9	117	(55) 47
South Kingstown														
Wakefield Elementary School														
South Kingstown Integrated Pre-school														
Peace Dale Elementary School														
South Kingstown High School	-	-	-	-	-	-	240	(206) 85.8	237	(198) 83.5	229	(174) 76	230	(121) 52.6
Curtis Corner Middle School	0	1	255	NA	266	(235) 88.3	-	-	-	-	-	-	-	-
West Kingston Elementary School														
Matunuck School														
Broad Rock Middle School														
Hopkinton Richmond Charlestown (Chariho)														
Chariho Regional High School														
Chariho Regional Middle School														
Charlestown Elementary School														
Richmond Elementary School														
Ashaway Elementary School														

TABLE 2: PARTICIPATION IN RISS, BY REGION, WITH NUMBER OF COMPLETED SURVEYS (N) AND RESPONSE RATE (%), BY GRADE LEVEL

Region	Grade Level													
	6		7		8		9		10		11		12	
	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%	RIDE	%
Hope Valley Elementary School														
The R.Y.S.E. School														
Westerly														
Westerly Middle School	219	(1) NA	206	(0) NA	233	(202) 86.7	-	-	-	-	-	-	-	-
Westerly High School	-	-	-	-	-	-	201	(152) 75.6	202	(104) 51.5	211	(140) 66.4	184	(4) 2.2
State Street School														
Dunn's Corners School														
Springbrook Elementary School														
Westerly Inclusion Preschool Program - Babcock Hal														
New Shoreham														
Block Island School	6	NA	9	(7) 77.8	9	(8) 88.9	13	(12) 92.3	12	(12) 100	14	(13) 92.9	8	(8) 100
Other														
Warwick														
Pilgrim High School	-	-	-	-	-	-	361	(262) 72.6	376	(286) 76.1	344	(230) 66.9	352	(2) 1
Toll Gate High School	-	-	-	-	-	-	265	(128) 48.3	314	(146) 46.5	338	(160) 47.3	266	(52) 19.5
Winman Junior High School							-	-	-	-	-	-	-	-
West Warwick														
West Warwick High School	-	-	-	-	-	-	314	(225) 71.7	234	(162) 69.2	229	(182) 79.5	232	(1) NA

Summary

Overall, only three regions met the requirement for participation in the RISS. Region 3 did not participate in the RISS and administers its own student survey (the Youth Experience Survey). Region 4 is not included in this summary due to the recency of its formation.

REGION 5: 100% of districts in Region 5 participated in the RISS with a minimum of two grade levels.

REGION 1: 83.3% of districts in Region 1 participated in the RISS with a minimum of two grade levels. No schools in North Providence participated in the RISS. Of the schools that participated, Cranston High School East, Hugh B. Bain Middle School, and Smithfield High School demonstrated insufficient response rates across all levels of administration (below the 60% threshold). Data regarding prevalence rates and risk and protective factors at these schools are unavailable for analysis.

REGION 7: 83.3% of districts in Region 7 participated in the RISS with a minimum of two grade levels. No schools in the Chariho district participated in the RISS.

Region 2: 42.9% of districts in Region 2 participated in the RISS with a minimum of two grade levels. One district participated with one grade level of administration due to insufficient response rates (below the 60% threshold) at all other grade levels. If this district is included in the total count of districts that participated, the percentage of districts that participated increases to 57.1%. No schools in three districts (Lincoln, North Smithfield, Central Falls) participated in the RISS.

Region 6: 50% of districts in Region 6 participated in the RISS with a minimum of two grade levels. One district participated with one grade level of administration due to insufficient response rates (below the 60% threshold) at all other grade levels. If this district is included in the total count of districts that participated, the percentage of districts that participated increases to 66.7%. No schools in two districts (Jamestown, Tiverton) participated in the RISS.

EFFECTIVENESS (CAPACITY/INFRASTRUCTURAL OUTCOMES)

Evidence-based policies, practices and programs

Regions were expected to increase use of evidence-based policies, practices, and programs (EPPP) by municipal substance abuse prevention coalitions across the lifespan. Given past municipal emphasis on implementation of evidence-based school-level programs, these data were selected as a baseline measure of evidence-based programs for this population. The CRST will monitor and report expansion of EPPP's across the lifespan in subsequent years of the RPTF.

Table 3 provides information regarding the number of classroom educational services reported within each region from the start of the project through August, 2018. Data were derived from the Mosaix Impact system.

TABLE 3: NUMBER OF CLASSROOM EDUCATIONAL SERVICES, BY REGION AND NUMBER SERVED

	Classroom Educational Service	-
1: Southern Providence		
Cranston	Positive Action	45
Foster	-	-
Glocester	-	-
Scituate	Life Skills	1098
North Providence	-	-
Smithfield	-	-
Johnston	Project Alert	250
2: Northern Providence/Blackstone Valley		
Burrillville	Project Alert	5
Woonsocket	-	-
Cumberland	-	-
Lincoln	-	-
Pawtucket	-	-
North Smithfield	-	-
Central Falls	-	-
3: Providence		
Providence	Positive Action	3185
5: East Bay		

TABLE 3: NUMBER OF CLASSROOM EDUCATIONAL SERVICES, BY REGION AND NUMBER SERVED

	Classroom Educational Service	-
East Providence	-	-
Barrington	-	-
Warren	-	-
Bristol	-	-
6: Newport		
Portsmouth	-	-
Little Compton	-	-
Jamestown	-	-
Tiverton	-	-
Middletown	-	-
Newport	Smart Moves Project Success- Prevention Education Michigan Model Health Curriculum	92 111 291
7: South County		
North Kingstown	-	-
Narragansett	-	-
South Kingstown	-	-
Hopkinton	-	-
Richmond	-	-
Charlestown	-	-
Westerly	-	-
New Shoreham	-	-

Summary: Based on information entered into the Mosaix system by regional and municipal coordinators, it is difficult to discern efforts to implement evidence-based classroom educational services in each region/municipality. It is also difficult to discern whether these efforts were made using RPTF funding or funding from other sources. Further information is necessary in order to evaluate how well regions are performing in increasing the number of EPPP's across the lifespan.

Implications: Standardization of the way data are entered into Mosaix may be necessary. The CRST is willing to provide training to improve the quality of data reported in this domain.

Environmental change strategies

Regions were expected to implement environmental change strategies to raise awareness of potential for harm, and reduce youth access to harmful legal products (e.g., products which might be legal for use by a segment of the population such as adults but which are not legal and are potentially harmful to others such as youth). Data were derived from the Mosaix Impact system.

Table 4 provides information regarding the number and type of environmental change strategies reported within each region from the start of the project through August, 2018 specific to potential for harm and youth access to harmful legal products.

These data were derived by selecting the following parameters from the 'Reports'/'Implementation'/'Single Services by Program' and 'Reports/'Implementation'/'Recurring Services by Program' modules in the Mosaix system:

SINGLE SERVICES
Start Date: 1/1/2017
End Date: 08/31/2018
Organization:

Organization
R1 Tri-County Community Action Coalition
R2 Blackstone Valley Regional Coalition
Mayor's Substance Abuse Prevention Council - (R3 Providence)
R4 Kent County Regional Coalition
R5 East Bay Regional Coalition
R6 Newport Regional Prevention Coalition
R7 Newport Regional Prevention Coalition

Program: Select All
Problem Behavior:

Region 1
(no behaviors available)

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Region 2
R2 Tobacco Use by underage youth
R2 Use of alcohol by underage youth

Region 3
R3 Providence MSAPC Underage Drinking
R3 Providence MSAPC Underage Use of Tobacco and Tobacco-Related Products

Region 4
Youth Use of Ends Products

Region 5
R5 East Bay Underage Alcohol Use
R5 East Bay Underage Tobacco Use

Region 6
R6 NCPC Tobacco
NCPC Substance Use

Region 7
(no behaviors specific to RPTF available)

Service Population: All
Service Location: All
IOM Category: All
Service Type Codes: Select All
CSAP Strategy: Environmental

RECURRING SERVICES
Start Date: 1/1/2017
End Date: 08/31/2018
Organization:

Organization
R1 Tri-County Community Action Coalition
R2 Blackstone Valley Regional Coalition
Mayor's Substance Abuse Prevention Council - (R3 Providence)
R4 Kent County Regional Coalition
R5 East Bay Regional Coalition
R6 Newport Regional Prevention Coalition
R7 Newport Regional Prevention Coalition

Program: Select All
Group: Select All
Problem Behavior:

Region 1
R1- TC Underage Drinking

Region 2
R2 Tobacco Use by underage youth
R2 Use of alcohol by underage youth

Region 3
R3 Providence MSAPC Underage Drinking
R3 Providence MSAPC Underage Use of Tobacco and Tobacco-Related Products

Region 4
Youth Alcohol Use
Youth Use of Ends Products

Region 5
R5 East Bay Underage Alcohol Use
R5 East Bay Underage Tobacco Use

Region 6
R6 NCPC Tobacco
NCPC Substance Use

Region 7
(no behaviors specific to RPTF available)

Service Population: All
Service Location: All
IOM Category: All
Service Type Codes: Select All
CSAP Strategy: Environmental

TABLE 4: NUMBER OF ENVIRONMENTAL CHANGE STRATEGIES BY REGION AND TYPE

SINGLE SERVICES BY PROGRAM		
	Youth Alcohol Use	Youth Tobacco Use
1: Southern Providence	0	0
2: Northern Providence/Blackstone Valley	0	0
3: Providence	0	3 (Social Norms Campaign Development; Providence Tobacco Education; Youth Empowerment Solutions (YES))

TABLE 4: NUMBER OF ENVIRONMENTAL CHANGE STRATEGIES BY REGION AND TYPE

SINGLE SERVICES BY PROGRAM		
	Youth Alcohol Use	Youth Tobacco Use
4: Kent County	0	0
5: East Bay	0	0
6: Newport	0	1 (NCPC Tobacco Policy)
7: South County	0	0
	RECURRING SERVICES BY PROGRAM	
	Youth Alcohol Use	Youth Tobacco Use
1: Southern Providence	0	0
2: Northern Providence/Blackstone Valley	0	0
3: Providence	1 (Providence Alcohol Vendor Education)	2 (Youth Empowerment Solutions (YES); Providence Tobacco Vendor Education)
4: Kent County	0	0
5: East Bay	0	0
6: Newport	0	0
7: South County	0	0

Summary: Based on the criteria entered into the Mosaix system, little to no efforts have been made by regions other than Providence to implement environmental change strategies targeting youth alcohol and tobacco use since the start of the project. However, this may be due to inconsistencies in the way data are reported to the Mosaix Impact system.

Implications: Standardization of the way data are entered into Mosaix may be necessary. The CRST is willing to provide training to improve the quality of data reported in this domain.

Media and communication strategies

Regions were expected to use media and communication strategies to promote positive behavioral health, increase the perception of risk or harm from substance use and correct normative misunderstandings of the norm among youth and young adults. Data were derived from the Mosaix Impact system.

Table 5 provides information on the number and type of media and communication strategies reported within each region from the start of the project through August, 2018.

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These data were derived by selecting the following parameters from the 'Reports'/'Implementation'/'Single Services by Program' and 'Reports/'Implementation'/'Recurring Services by Program' modules in the Mosaix system:

SINGLE SERVICES
Start Date: 1/1/2017
End Date: 08/31/2018
Organization:

Organization
R1 Tri-County Community Action Coalition
R2 Blackstone Valley Regional Coalition
Mayor's Substance Abuse Prevention Council - (R3 Providence)
R4 Kent County Regional Coalition
R5 East Bay Regional Coalition
R6 Newport Regional Prevention Coalition
R7 Newport Regional Prevention Coalition

Program: Select All
Problem Behavior:

Region 1
R1- TC- Youth Marijuana Use
R1- TC- Opioid Misuse and Abuse
R1- TC- Prescription Drug Misuse
R1- TC- Underage Drinking

Region 2
R2 Mental Health issues
R2 Opioid Misuse
R2 Tobacco Use by underage youth

Region 2
R2 Use of alcohol by underage youth
R2 Youth Marijuana Use

Region 3
R3 Providence MSAPC Underage Drinking
R3 Providence MSAPC Lack of Mental Health Promotion
R3 Providence MSAPC Prescription Drug Abuse and Opioid Misuse
R3 Providence MSAPC Underage Use of Tobacco and Tobacco-Related Products
R3 Providence MSAPC Youth Marijuana Use

Region 4
Youth Alcohol Use
Youth Marijuana Use
Youth Use of Ends Products
Youth Use of non-medical prescription drugs
NCPC Substance Use

Region 5
R5 East Bay Lack of Mental Health Promotion
R5 East Bay Opioid misuse
R5 East Bay Underage Alcohol Use
R5 East Bay Underage Tobacco Use
R5 East Bay Youth Marijuana Use
R5 East Bay Youth Substance Use

COMMUNITY RESEARCH & SERVICES TEAM (CRST) - UNIVERSITY OF RHODE ISLAND

Region 6
R6 NCPC Tobacco
NCPC Substance Use

Region 7
(no behaviors specific to RPTF available)

Service Population: All
Service Location: All
IOM Category: All
Service Type Codes: Select All
CSAP Strategy: All

RECURRING SERVICES
Start Date: 1/1/2017
End Date: 08/31/2018
Organization:

Organization
R1 Tri-County Community Action Coalition
R2 Blackstone Valley Regional Coalition
Mayor's Substance Abuse Prevention Council - (R3 Providence)
R4 Kent County Regional Coalition
R5 East Bay Regional Coalition
R6 Newport Regional Prevention Coalition
R7 Newport Regional Prevention Coalition

Program: Select All
Group: Select All
Problem Behavior:

COMMUNITY RESEARCH & SERVICES TEAM (CRST) - UNIVERSITY OF RHODE ISLAND

Region 1
R1- TC- Youth Marijuana Use
R1- TC- Opioid Misuse and Abuse
R1- TC- Prescription Drug Misuse
R1- TC- Underage Drinking

Region 2
R2 Mental Health issues
R2 Opioid Misuse
R2 Tobacco Use by underage youth
R2 Use of alcohol by underage youth

Region 3
R3 Providence MSAPC Underage Drinking
R3 Providence MSAPC Lack of Mental Health Promotion
R3 Providence MSAPC Prescription Drug Abuse and Opioid Misuse
R3 Providence MSAPC Underage Use of Tobacco and Tobacco-Related Products
R3 Providence MSAPC Youth Marijuana Use

Region 4
Youth Alcohol Use
Youth Marijuana Use
Youth Use of Ends Products
Youth Use of non-medical prescription drugs
NCPC Substance Use

Region 5
R5 East Bay Lack of Mental Health Promotion
R5 East Bay Opioid misuse
R5 East Bay Underage Alcohol Use
R5 East Bay Underage Tobacco Use
R5 East Bay Youth Marijuana Use
R5 East Bay Youth Substance Use

Region 6
R6 NCPC Tobacco
NCPC Substance Use

Region 7
(no behaviors specific to RPTF available)

Service Population: All
Service Location: All
IOM Category: All
Service Type Codes: Select All
CSAP Strategy: All

TABLE 5: NUMBER OF MEDIA AND COMMUNICATION STRATEGIES REPORTED BY REGION

SINGLE SERVICE	
	Strategies
1: Southern Providence	0
2: Northern Providence/Blackstone Valley	2 (Cumberland Lincoln Newsletter; Media Campaign: Count It, Lock it, Drop It)

TABLE 5: NUMBER OF MEDIA AND COMMUNICATION STRATEGIES REPORTED BY REGION

SINGLE SERVICE	
	Strategies
3: Providence	9 (PFS Providence Power of Parents Local Media Campaign; PFS Providence Above the Influence; PFS Providence Positive Action; PFS Providence Family Matters; R3 Providence Promoting Positive Community Norms; R3 Providence Tobacco Education; R3 Providence Youth Empowerment Solutions; R3 Providence Count It, Lock It, Drop It Local Media Campaign; R3 Providence Overdose education among 10th grade)
4: Kent County	0
5: East Bay	0
6: Newport	0
7: South County	0
RECURRING SERVICES	
1: Southern Providence	0
2: Northern Providence/Blackstone Valley	2 (Cumberland Lincoln Newsletter; Media Campaign: Count It, Lock it, Drop It)
3: Providence	7 (PFS Providence Above the Influence; PFS Providence Youth Sports; PFS Providence Positive Action; Power of Parents Local Media Campaign; Sticker Shock Local Media Campaign (alcohol); Providence Count It, Lock It, Drop It Local Media Campaign; Providence Family Matters)
4: Kent County	0
5: East Bay	0
6: Newport	0
7: South County	1 (Online Parenting Newsletter)

Summary: Based on the criteria entered into the Mosaix system, little to no efforts have been made by regions other than Providence and Region 2 (Northern Providence/BVPVC) to implement media and communication strategies promoting positive behavioral health, increasing the perception of risk or harm from substance use and correcting normative misunderstandings of the norm among youth and young adults since the start of the project.

However, this may be due to inconsistencies in the way data are reported to the Mosaix Impact system. Of note, it is unclear from the Mosaix system whether the media and communications activities reported above for Providence were conducted under the PFS-2013 or RPTF projects. Likewise, many of the recurring services are also listed as singe services.

Implications: Standardization of the way data are entered into Mosaix may be necessary. The CRST is willing to provide training to improve the quality of data reported in this domain.

EFFECTIVENESS (INDIVIDUAL SCHOOL-AGED YOUTH OUTCOMES)

Peer Disapproval

Regions were expected to monitor the percentage of in-school, school-aged youth expressing disapproval of use of alcohol, tobacco, and other drugs.

Table 6* will provide information regarding the percentage of youth within each region who 'highly agree' and 'agree' with the statement that "…" Data are derived from the 2017-2018 administration of the RISS and provide baseline estimates for the remainder of the project.

Prevalence

Regions were expected to monitor the percentage of in-school, school-aged youth reporting current (past 30-day) use of alcohol, tobacco, and other drugs.

Table 7* will provide information regarding the percentage of youth who reported any past 30-day use on the RISS by region. These data provide baseline estimates of prevalence for the remainder of the project.

*__Table 6__ and __Table 7__ will be provided to BHDDH after further analysis of the 2017-2018 RISS dataset. This dataset was provided to the CRST by the CPRC in August, 2018. Due to time constraints, processing of peer disapproval and prevalence data was not yet complete at the time this report was compiled. Complete analysis of these data is expected by September 30, 2018.

SECTION B: RHODE ISLAND STUDENT ASSISTANT SERVICES - PROJECT SUCCESS

OVERVIEW

In accordance with the aims of the cooperative agreement, the CRST will conduct a state-level evaluation of the Rhode Island Student Assistant Services- Project Success program using data obtained from the RISS and the Mosaix systems.

Process evaluation

The process evaluation measures fidelity to the Project Success model, with particular attention to the four-module Prevention Education Series. Project Success is an evidence-based curriculum with fidelity measures available from the program developers. To achieve this goal, the CRST, in collaboration with Sarah Dinklage and Colleen Judge of Project Success, agreed to begin monitoring of fidelity during the 2017-2018 school year.

In order to ensure that student assistance counselors complete fidelity measures after each prevention education series module, the CRST will provide Sarah Dinklage and Colleen Judge with a guidance document for distribution to program supervisors and administrators. These documents are available in Appendix B-1 and B-2, respectively.

The CRST will be available to provide TA regarding fidelity measures, as needed. These measures will be compiled by the CRST to determine the percentage of schools/student assistance counselors administering the Prevention Education Series with adequate fidelity to the model.

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SECTION C: RHODE ISLAND PREVENTION RESOURCE CENTER (RIPRC)

EVALUATION PLAN

The CRST completed a detailed plan for evaluation of the RIPRC. The following information details this plan.

Objective

According to the scope of work described and approved in the Cooperative Agreement between the Community Research and Services Team (CRST) at the University of Rhode Island and the Department of Behavioral Health, Developmental Disabilities and Hospitals (hereafter referred to as BHDDH), the CRST will:

> "…conduct state level process and outcome evaluation of the Rhode Island Prevention Resource Center (RIPRC) program using data obtained from the Mosaix IMPACT system… The process evaluation will measure RIPRC service satisfaction. CRST will perform an annual satisfaction survey monkey on those who have participated in training or received technical assistance from RIPRC. CRST will perform key informant interviews via phone with a percentage of the training and technical assistance recipients. A report will be provided with the results…"

Goals

As described in a meeting with Shannon Spurlock, MA and Angelique Higgins of the Prevention Resource Center (RIPRC) and Dorothy Skierkowski-Foster, PhD of the CRST on August 8, 2018, the primary objectives of the RIPRC evaluation are to:

1. identify ***how*** individuals who participate in training and technical assistance provided by the PRC utilize the information and skills disseminated through training and technical assistance in their respective prevention-related work, and;
2. identify ***barriers to implementation*** of skills and knowledge acquired through training and technical assistance.

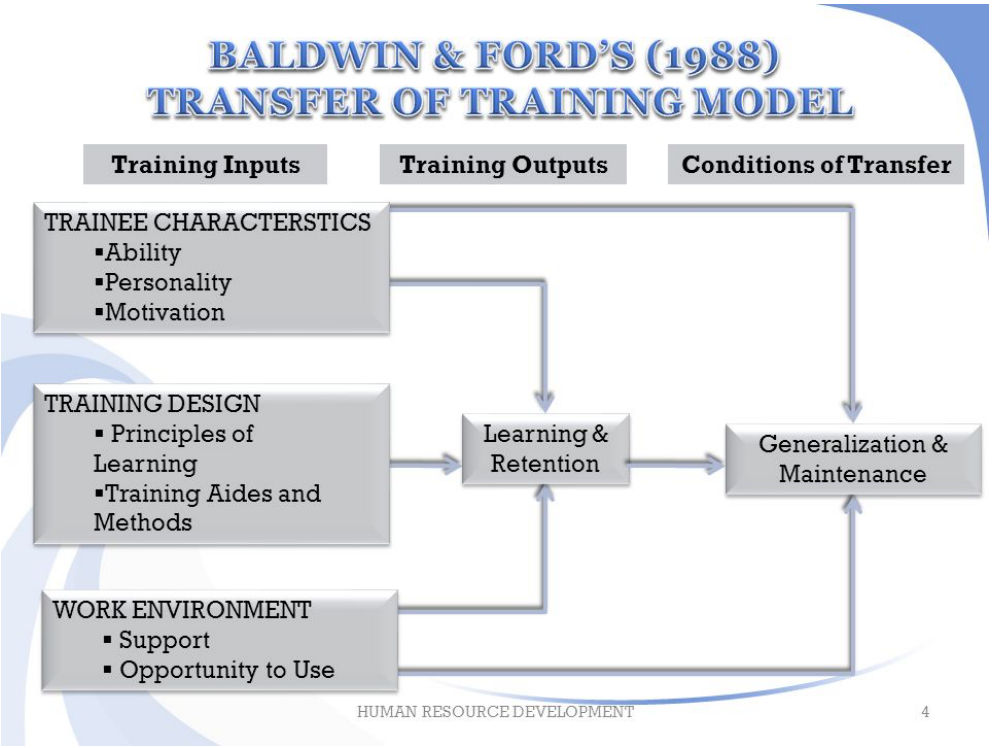
To this end, the RIPRC would like to focus evaluation efforts on the following sub-domains of training and technical assistance identified by the RIPRC, listed in order of prioritization:

- *Trainings*, defined as planned prevention education/skill-building events with an established curriculum and clearly delineated learning objectives,
- *Proactive technical assistance*, defined as consumer-driven technical assistance that is planned in advance and in response to pre-defined needs by key constituents (includes learning collaboratives, group TA, and certification prep), and

- *Reactive technical assistance,* defined as technical assistance that is spontaneous, unplanned, and oftentimes occurs 'in-the-moment' after meetings, workshops, or other prevention-related events with key consumers.

Theory

Factors that influence *transfer of training* have been studied extensively in the fields of psychology and education for the past century. One of the most commonly cited models of training transfer was developed by Baldwin and Ford (1988). This model is organized around *training inputs* (trainee characteristics, training design, and work environment), *training outputs* (acquisition of knowledge and skills during training), and c*onditions of transfer* (generalization of knowledge and skills acquired during training to the job and the maintenance of learning over time in the work environment).

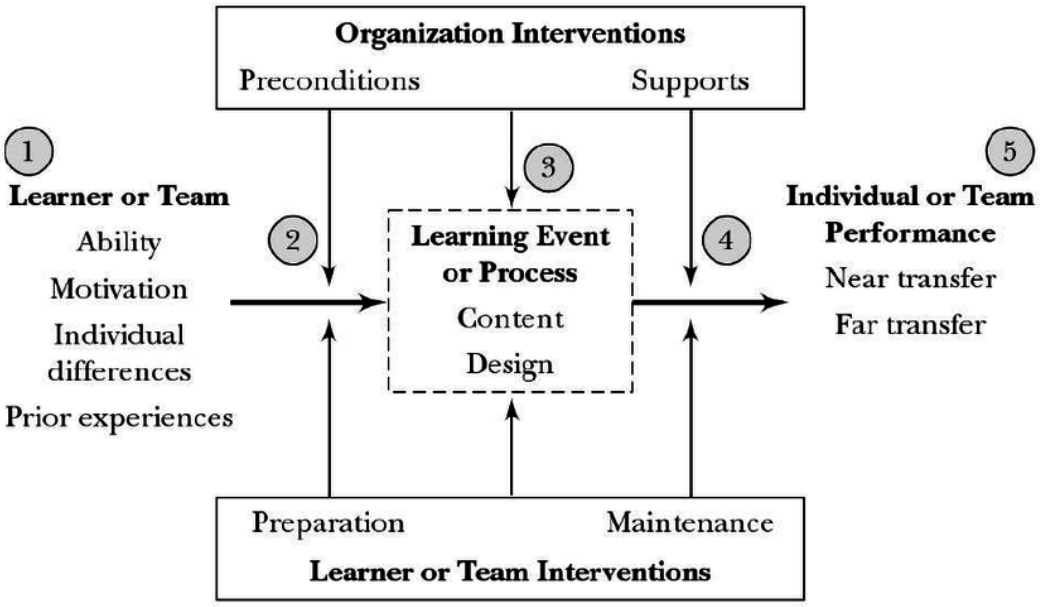


Training inputs. Trainee characteristics measure elements such as ability, skill, motivation, and individual personality characteristics. Training design refers to the training objectives, principles of learning employed in the training, and methods of practice. Work environment includes elements such as climate, support from peers/ supervisors, and opportunities for performing skills learned in training in the workplace.

Training outputs. Learning and retention refer to the acquisition of skills and knowledge resulting from the transfer of training.

Conditions of transfer. Generalization refers to the extent to which skills and knowledge acquired in a training session are applied to different setting. Maintenance refers to the degree to which skills and knowledge learned in a training session persist over time.

Holton & Baldwin (2003) refined this process to include elements related to near and far transfer, as well as organizational and team factors that may contribute to generalization and maintenance. The Learning Transfer System Inventory (LTSI) was developed and validated by Holton, Bates and Ruona (2000) to measure factors influencing learning transfer. The CRST will utilize the theory behind this scale in order to develop specific questions related to the transfer of learning across training and technical assistance sessions administered by the RIPRC, if the measure is not directly available to the researchers. The following figure describes Holton and Baldwin's (2003) model for transfer of training.



Solution

In order to meet these objectives, the CRST will focus the evaluation on understanding how consumers of *trainings and proactive technical assistance* provided by the RIPRC utilize knowledge and skills acquired in the six months after completion of these events. Furthermore, the CRST will investigate barriers to implementation of any behavioral objectives following completion of proactive technical assistance and trainings.

In order to build upon existing infrastructure, consumers of training and technical assistance will be required to complete a post-training/TA satisfaction survey, currently administered by the RIPRC. Surveys will include an additional short set of questions related to *intent to utilize information obtained in the TA/training within the next six months.* These questions will be guided by Baldwin and Ford's (1988) and Holton and Baldwin's (2003) theory

of transfer of training. Consumers will be asked to participate in a six-month follow-up assessment, at which time they will be provided with a pre-defined list of intended behavioral outcomes from each TA/training session (to be decided in collaboration with the RIPRC). Likewise, barriers to successful implementation of these objectives will also be assessed.

Per request of the RIPRC, assessment of ***reactive technical assistance*** will be addressed at a future date.

The outcome evaluation will provide information on the number of completed requests for trainings/technical assistance, as well as overall attendance at events and global satisfaction with services provided. Information regarding the number of completed requests and attendance will be obtained from the IMPACT/Mosaix system. Information regarding overall satisfaction with service will be obtained from existing satisfaction surveys administered by the RIPRC after each training session.

Project Outline

The CRST proposes the following 2018 schedule for the process and outcome evaluation of the RIPRC:

- August, 2018
  - Meet with RIPRC staff to determine RIPRC evaluation needs
  - Develop additional behavioral intent questions for inclusion on post-***training*** and p***roactive technical assistance*** satisfaction surveys
  - Monitor requests for ***proactive technical assistance***
- September, 2018
  - Obtain LTSI measure, if available from developers
  - Develop six-month follow-up survey for ***proactive technical assistance*** and ***training*** participants
  - Monitor requests for ***proactive technical assistance***
- October, 2018
  - RIPRC to administer post-training survey at Mental Health First Aid Training (sponsored training event by RIPRC), with additional items developed by CRST and permission to contact participants at six-month follow-up
  - Monitor requests for ***proactive technical assistance***
- November, 2018
  - RIPRC to administer post-training survey at first in-house training (created by the RIPRC), with additional items developed by CRST and permission to contact participants at six-month follow-up
  - Monitor requests for ***proactive technical assistance***
- December, 2018
  - RIPRC to administer post-training survey to e-learning participants (program created by the RIPRC), with additional items developed by CRST and permission to contact participants at six-month follow-up
  - Monitor requests for ***proactive technical assistance***
- January, 2019

- Compile preliminary report regarding number of ***proactive technical assistance*** and ***training*** sessions offered from start of BHDDH contract
- Provide aggregated feedback regarding satisfaction data from surveys administered after all trainings in contract term
- Report preliminary results to BHDDH

- February, 2019
  - Administer first six-month follow survey to participants who completed ***trainings*** or ***practice technical assistance*** in September, 2018

References

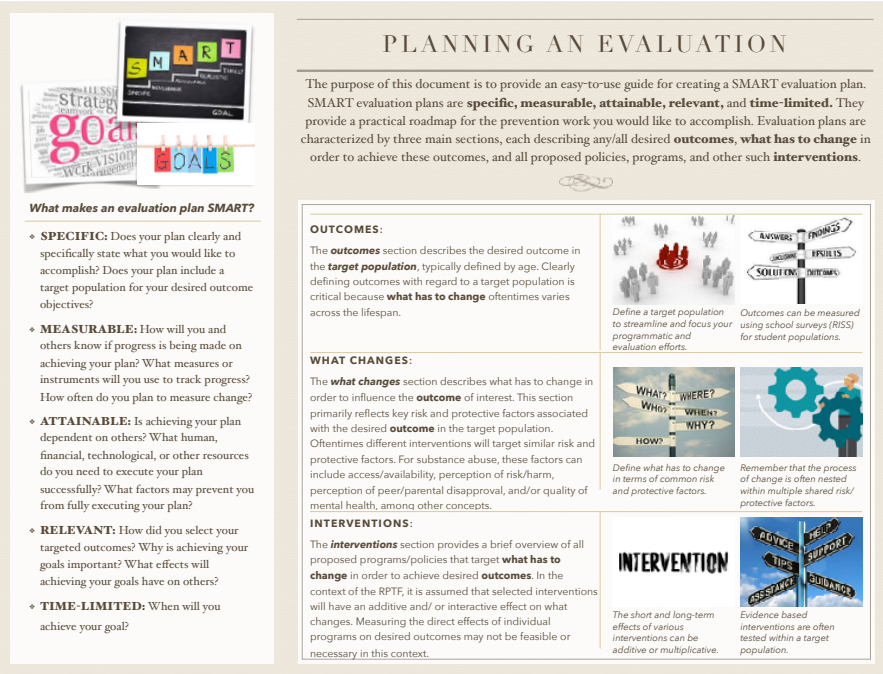
Baldwin, T. T., & Ford, J. K. (1988). Transfer of training: A review and directions for future research. *Personnel Psychology*, *41*(1), 63-105.

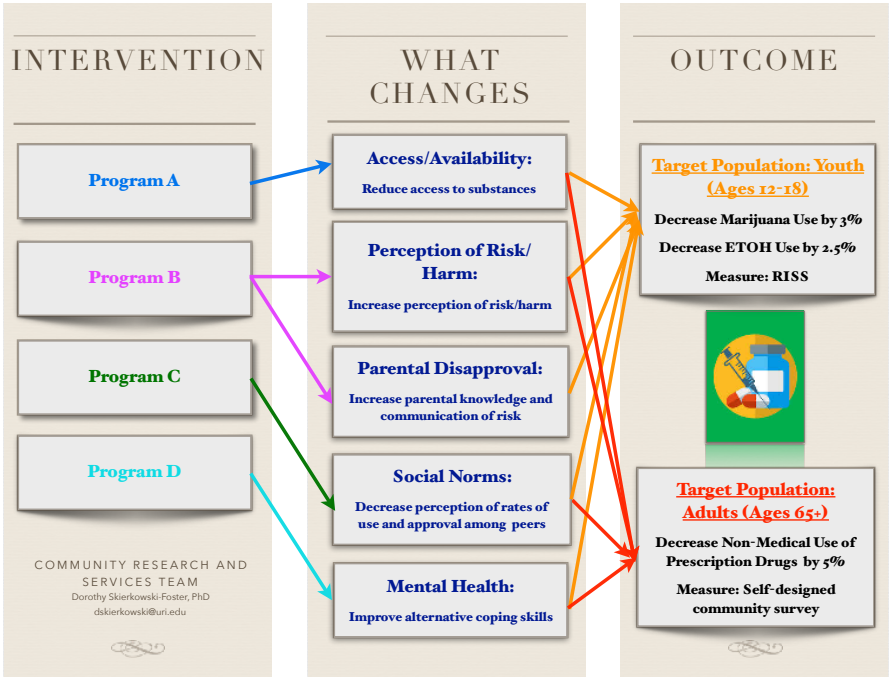
Holton, E. F., & Baldwin, T. T. (2003). Making transfer happen: An action perspective on learning transfer systems. *Improving Learning Transfer in Organizations*, *3*(5).

Holton III, E. F., Bates, R. A., & Ruona, W. E. (2000). Development of a generalized learning transfer system inventory. *Human Resource Development Quarterly*, *11*(4), 333-360.

APPENXIX A-1: RPTF COALITION SURVEY RESULTS

APPENXIX A-2: SMART EVALUATION GUIDANCE DOCUMENT





APPENXIX A-3: RPTF ATTENDANCE TRACKING DOCUMENT

RPTF COALITION MEETING

Attendance Sheet **Date: ________**

Instructions: Please include your name, organization, title, and sector representation in the space provided. Please also provide the name, organization, and title of the individual who referred you to the RPTF.

SECTORS (check all that apply):

BUSINESS: including pharmacies, retail stores, and local area employees

EDUCATION: including schools, colleges and universities, local education agency

SAFETY: including police and fire departments, local EMS

MEDICAL/HEALTH: including community health centers and community mental health centers, hospitals, health care provider representatives

GOVERNMENT: including municipal government, department of health, parks and recreation

COMMUNITY/FAMILY SUPPORTS: including community centers, Y, youth serving organizations

Name/ Organization/Title	I am a Municipal Coordinator	Business	Education	Safety	Medical/ Health	Government	Community/ Family Supports	This is my first meeting with the RPTF.	I was referred to the RPTF by:
Jane Doe, Anytown Pharmacy, Pharmacist	☐	☑	☐	☐	☐	☐	☐	☐	John Deer, Anytown Pharmacy, Store Manager
	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	
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	☐	☐	☐	☐	☐	☐	☐	☐	

APPENXIX B-1: RISAS STUDENT ASSISTANCE COUNSELOR SUPERVISOR LETTER

TO: Student Assistance Counselor, "Prevention Education Series" of Project Success
FM: Dorothy Skierkowski-Foster, Ph.D., Community Research and Services Team (CRST), Statewide Evaluation
RE: Curriculum Implementation Fidelity Measures

Your community is implementing "Prevention Education Series" of *Project Success* an "evidence-based" curriculum. This curriculum has been proven in previous efficacy trials and, in several cases, have produced results in effectiveness trails (e.g., delivered in the field by others than the developers). The assumption is therefore that, if implemented with fidelity, each curriculum will produce effects.

Considerable research points to the importance of quality implementation. One major review found mean effect sizes favoring better implementation are two to three times higher than with poorer implementation. With this in mind, BHDDH is requiring all those student assistant counselor / health educators / teachers and others who deliver your evidence-based curriculum to complete the attached Program Implementation Fidelity measures.

The **purpose** of the Program Implementation Fidelity measures is to evaluate fidelity (adherence to planned content), perceived responsiveness of students and to track any adaptations that may be made to the curriculum. Checklists are to be completed immediately after each topic is delivered (some topics will take more than one class). *It will be your responsibility, as the Student Assistant Counselor for your school, to ensure that these measures are completed by all the instructors for all of the classes and all of the grades that are receiving the* "Prevention Education Series" of *Project Succes*

The **results** of these measures can be used by you and your local school /community to assess how the intended curriculum is unfolding over time. You will be responsible for transmitting these measures to the CRST who will then summarize the data and present them to BHDDH.

These measures will **not** be **anonymous**, because you will need to keep records for each instructor and his / her curriculum implementation. But they **can be confidential** in that you need not supply any names when you send the information on to the CRST (simply blank the names out). In addition, you should emphasize to those who deliver your curriculum to be as candid as possible in their responses because these measures are designed not to judge them, but to understand more fully the challenges faced by those implementing evidence-based curricula in real-world settings such as their school. You may also want to remind them that good "fidelity" doesn't necessarily mean one hundred percent adherence to all lesson components all the time. For example, in the aforementioned review, positive program results were visible in programs with at least 60% coverage of the intended material. Finally, mention also that "adaptations" are not necessary deviance from the program design, but can be additions or modifications by the facilitator to the program setting and characteristics of the population, including increasing culturally appropriateness in a given context. We've created a "briefing sheet" that you can use to emphasize these points when orienting your instructors to the forms.

We look forward to working with you.

APPENXIX B-2: RISAS STUDENT ASSISTANCE COUNSELOR (SAC) FIDELITY GUIDELINES

Implementation Fidelity Measures for

Prevention Education Series of *Project Success*

What are these forms?

- Implementation Checklists to be completed immediately after each topic is completed. (Note: A topic may take more than 1 class to complete.)

What is the purpose of these forms?

- To evaluate "fidelity" or adherence to the planned content of the curriculum.
- To rate the perceived responsiveness of students to each lesson.
- To track adaptations (additions, deletions, modifications) made to the curriculum. Note these in the "General Comments" section of each form.

How will results be used?

- To assess how the intended curriculum unfolds over time and is received by students.
- To determine how much of the intended curriculum gets delivered.
- As data for summary reports of implementation to BHDDH.

Should you be honest and candid in your responses?

- Yes, because these forms are not being used to assess your capacity to deliver the curriculum, but instead are attempting to capture how and what was covered for each lesson.
- Yes, because the measures are designed to more fully understand the challenges faced by those implementing an evidence-based curriculum in the real-world setting of schools.
- Yes, because you don't need to be perfect in covering every topic every session. Research from evidence-based curriculums show positive results were visible in programs with 60% coverage of the material or more.
- Yes, because while you should certainly attempt fidelity when implementing an evidence-base curriculum, not all adaptations are "deviance" from the program design. Some modifications or additions can make the curriculum fit better with your setting or population, including cultural adaptations. In fact, studies that have examined the relation between adaptation and outcomes have reported a positive effect of adaptation.

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

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

Integrated Health Home (IHH): is built on the person-centered medical home model that enhances the coordination of medical and behavioral healthcare. IHH provides linkages to community and social supports. The IHH team is made up of a program director, registered nurses, hospital liaison, employment specialists, peer specialist and a medical assistant. The team's goal is to work within the client's plan to ensure the person's stability in the community through the coordination of care, mental health promotion and peer/family support. Services include care coordination and health promotion; chronic condition management; comprehensive transition care; and individual and family support services. IHH provides clients with access to the following practice: Psychopharmacological Treatment, Integrated Dual Diagnosis Treatment, Individual Placement and Supports, Family Psychoeducation, Clubhouse, Clinician Services- Disorder Specific Services, Crisis Assessment and Intervention Services, Supportive Employment and Education Services, and Psychiatric Rehabilitation.

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

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

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

Mental Health Psychiatric Rehabilitative Residences are programs that provide care for individuals who require increased structure due to their chronic mental illness may meet the group home level of care. Individuals must have a severe and persistent mental illness and be unable to live in a less restrictive setting in the community. They operate 24 hours a day, 7 days a week providing services and supervision to individuals in community settings. Services include promoting recovery and empowering individuals to improve or restore overall functioning.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	Yes	No
b)	Mental Health	Yes	No
c)	Rehabilitation services	Yes	No
d)	Employment services	Yes	No
e)	Housing services	Yes	No
f)	Educational Services	Yes	No
g)	Substance misuse prevention and SUD treatment services	Yes	No
h)	Medical and dental services	Yes	No
i)	Support services	Yes	No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	Yes	No
k)	Services for persons with co-occuring M/SUDs	Yes	No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state's case management services

Assertive Community Teams (ACT) includes a multidisciplinary staff to provide these support services to those who meet specific diagnostic and functional criteria assessed through the DLA tool. BHDDH has created an exception process for individuals who do not meet diagnostic criteria but require IHH services; e.g., individuals experiencing chronic homelessness who are cycling through emergency departments and institutions).

4. Describe activities intended to reduce hospitalizations and hospital stays.

BH Link is a program to support individuals in crisis for behavioral health issues through telephone hotlines, mobile outreach and a dedicated behavioral-health, community-based facility that provides a short-term alternative to emergency department triage that links people to treatment in the community.

BH Link is a program to support individuals in crisis for behavioral health issues through telephone hotlines, mobile outreach and a dedicated behavioral-health, community-based facility that provides a short-term alternative to emergency department triage that links people to treatment in the community. The triage center is located in East Providence, RI and opened in November 2018. It was highly promoted as a resource by the Governor's office as a resource during the COVID-19 pandemic

Crisis Stabilization Units is a short term acute psychiatric hospital step-down or diversionary program. These programs have complete diagnosis and assessment capabilities with psychiatric and nursing services funded by health insurance or Medicaid. This service provides short-term stabilization and treatment necessary to prevent re-hospitalization or long-term residential treatment.

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

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

N/A

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	52,914	286 per 100,000 per year
2.Children with SED	10,633	323 per 100,000 per year

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Statewide prevalence of adult SMI was calculated using the 2021 NSDUH estimate for adults aged 18+ with SMI in Rhode Island, 5.99%. This percentage was multiplied by SAMHSA's population estimate of adults aged 18+ in RI based on 2021 URS reports, 883,380 people.

Statewide incidence of SMI was calculated using 2022 data from BHOLD. From January to December of 2022, there were 2,549 unique new admissions of adults aged 18+ in RI with SMI who were enrolled in a MH program and did not have a prior admission in BHOLD. A rate per 100,000 per year was calculated by dividing this number of new admissions by the 2022 census estimate of adults aged 18+ in RI. This estimate does not reflect all possible adults with SMI in the state.

Statewide prevalence of children with SED was calculated using the 2022 URS estimate for Rhode Island. The above number represents the average of the upper and lower estimates for children with SED aged 9-17 with a level of functioning score equal to 60.

Statewide incidence of children with SED was calculated by determining the number of unique new admissions of children aged 1 -17 with SED from January-December 2022 who were enrolled in an MH program and did not have a prior admission in BHOLD. This number, 658, was divided by the 2022 US census estimate of children under the age of 18 in RI to obtain a rate per 100,000. This estimate does not reflect all possible children with SED in RI. Children's behavioral health services are under the jurisdiction of the Department of Children, Youth, and Families, and thus the above estimate are likely underestimates.
The Planning Unit collaborates with the Data Unit on all activities related to program development and the development of deliverables. The Data Unit provides the expertise of epidemiologist and has access to multiple data sources, both national and state. They also work to develop the needs assessment which influences planning decisions.

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

Rhode Island is currently receiving TA for SED and determining prevalence is a point of discussion.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

a)	Social Services	● Yes	○ No
b)	Educational services, including services provided under IDEA	● Yes	○ No
c)	Juvenile justice services	● Yes	○ No
d)	Substance misuse preventiion and SUD treatment services	● Yes	○ No
e)	Health and mental health services	● Yes	○ No
f)	Establishes defined geographic area for the provision of services of such systems	● Yes	○ No

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

Rhode Island is currently receiving TA for SED.

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

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

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

Community Mental Health Centers are divided by catchment areas that cover 100% of Rhode Island. We have expanded mobile crisis services through the state regardless of geography as part of the state's push towards statewide utilization of the CCBHC model

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

"Opening Doors RI" is Rhode Island's strategic plan to prevent and end homelessness. Adopted in 2012, the implementation plan was updated in 2016. The plan is consistent with federal priorities to decrease the number of individuals experiencing homelessness and to decrease the length of time individuals remain homeless. RI's plan prioritizes preventing and ending homelessness among veterans and to end chronic homelessness. Key initiatives target individuals experiencing chronic homelessness, veterans, families and youth. Additionally, we have used block grant funds to expand the services provided through PATH, with a focus on those who do not qualify for PATH.
Lastly, the Department is funding a series of trainings for providers, with the primary goal of ensuring that the most vulnerable people experiencing chronic homelessness receive access to housing, treatment, and recovery support services. These trainings are important to ensure the best quality of care in both the behavioral health and homeless prevention service worlds. These trainings are available to CMHC's case managers, outreach workers, peers, clinicians, and other staff who do not always come to employment trained in best practices for behavioral health and homelessness prevention services

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

The Department participates in a monthly workgroup devoted to addressing the behavioral health needs of older adults in Rhode Island. BH Link has expanded to include a relationship with the Department of Elderly Affairs to include their staff to coordinate services for older adults. We also offer trainings for older adults through RI Office of Healthy Aging.

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

N/A

Narratve Question

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

The Department funds a percentage of fiscal, operations, and the data and monitoring unit to the block grants. All these specialty staff are involved in the implementation of the plan. The block grant planner and epidemiologist are attributed to the block grant to ensure the success of the assessment, plan, and accurate, timely reporting. The Data unit assists with the identification and analysis of data from our State's MMIS and BHOLD databases. The Fiscal unit is responsible for budget reports and invoices. Contracts is in the Behavioral Health Division as well.

BHDDH has procured a contract with the Substance Use Mental Health Leadership Council (SUMHLC) which provides training and technical assistance. This organization, in collaboration with BHDDH, provides prescribed training to all CMHCs and provider agencies in the continuum. SUMHLC also advocates for behavioral health programing, funding, and legislation with state government. The SUMHLC contract is amended as needed to provide services and the budget is adjusted when additional funding is received for TA purposes.

BHDDH also partners with the Mental Health Association, NAMI, Horizon Health Partners, C4 Innovations, and Court Diversion to provide training/education to providers of emergency health services regarding SMI and SED.

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

The Rhode Island General Assembly has passed legislation that expands telemedicine coverage requirements for insurers and require that all Rhode Island Medicaid Programs cover telemedicine visits with health care providers via telephone or audio-video enabled device. This legislation applies to the treatment of individuals with SMI/SED

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

N/A

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	◉ Yes	○ No
ii)	Education	◉ Yes	○ No
iii)	Brief Intervention	◉ Yes	○ No
iv)	Assessment	◉ Yes	○ No
v)	Detox (inpatient/residential)	◉ Yes	○ No
vi)	Outpatient	◉ Yes	○ No
vii)	Intensive Outpatient	◉ Yes	○ No
viii)	Inpatient/Residential	◉ Yes	○ No
ix)	Aftercare; Recovery support	◉ Yes	○ No

b) Services for special populations:

i)	Prioritized services for veterans?	○ Yes	◉ No
ii)	Adolescents?	◉ Yes	○ No
iii)	Older Adults?	○ Yes	◉ No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? ( ) Yes (●) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance ( ) Yes (●) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The requirement to monitor program compliance for PWWDC is established in all contracts in order to provide the State with recourse should an agency be found in need of corrective action. Additionally, State staff conduct "secret shopper" functions to confirm compliance. If an agency is found to not to be in compliance, a graduated process is initiated that begins with a BHDDH administrator contacting the CEO of the agency to determine the extent of the concern. Depending on the response (e.g., specific staff error, policy error, funding issue) a corrective action plan is established.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

- **a)** 90 percent capacity reporting requirement — (●) Yes ( ) No
- **b)** 14-120 day performance requirement with provision of interim services — (●) Yes ( ) No
- **c)** Outreach activities — (●) Yes ( ) No
- **d)** Syringe services programs, if applicable — (●) Yes ( ) No
- **e)** Monitoring requirements as outlined in the authorizing statute and implementing regulation — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Electronic system with alert when 90 percent capacity is reached — ( ) Yes (●) No
- **b)** Automatic reminder system associated with 14-120 day performance requirement — ( ) Yes (●) No
- **c)** Use of peer recovery supports to maintain contact and support — (●) Yes ( ) No
- **d)** Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)? — ( ) Yes (●) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The state has worked to improve access to PWID services. As a result, there is no current waitlist for MAT-MOUD services. Wait periods and interim service requirements are in all contracts for SUD residential.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? — ( ) Yes (●) No

2. Has your state identified a need for any of the following:

- **a)** Business agreement/MOU with primary healthcare providers — ( ) Yes (●) No
- **b)** Cooperative agreement/MOU with public health entity for testing and treatment — ( ) Yes (●) No
- **c)** Established co-located SUD professionals within FQHCs — (●) Yes ( ) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Audit reviews at physical exams provide proof of referral and follow up as needed.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? — ( ) Yes (●) No

2. Has your state identified a need for any of the following:

- **a)** Establishment of EIS-HIV service hubs in rural areas — ( ) Yes (●) No
- **b)** Establishment or expansion of tele-health and social media support services — ( ) Yes (●) No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS

○ Yes ◉ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)?

◉ Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?

◉ Yes ○ No

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program?

○ Yes ◉ No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (●) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — ( ) Yes (●) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ( ) Yes (●) No
- **f)** Explore expansion of services for:
  - **i)** MOUD — ( ) Yes (●) No
  - **ii)** Tele-Health — ( ) Yes (●) No
  - **iii)** Social Media Outreach — ( ) Yes (●) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ( ) Yes (●) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — ( ) Yes (●) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ( ) Yes (●) No
- **b)** An organized referral system to identify alternative providers? — ( ) Yes (●) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — ( ) Yes (●) No

b) Review of current levels of care to determine changes or additions — ○ Yes ● No

c) Identify workforce needs to expand service capabilities — ● Yes ○ No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — ● Yes ○ No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — ● Yes ○ No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — ○ Yes ● No

b) Training on responding to requests asking for acknowledgement of the presence of clients — ○ Yes ● No

c) Updating written procedures which regulate and control access to records — ○ Yes ● No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — ○ Yes ● No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — ● Yes ○ No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

5 sites

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — ○ Yes ● No

b) Establishment of policies and procedures related to independent peer review — ○ Yes ● No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — ○ Yes ● No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ● Yes ○ No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☑ Other (please specify)

SUD in JACHO, CARF, COW established.

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ● No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ● No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ● No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state ● Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ● Yes ○ No

c) Performance-based accountability: ○ Yes ● No

d) Data collection and reporting requirements ● Yes ○ No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ○ Yes ● No

b) Addition of training sessions designed to increase employee understanding of recovery support services ○ Yes ● No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ○ Yes ● No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ○ Yes ● No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ● Yes ○ No

b) Mental Health TTC? ○ Yes ● No

c) Addiction TTC? ● Yes ○ No

d) State Targeted Response TTC? ○ Yes ● No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ● No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ● Yes ○ No

b) Early Intervention Services Regarding HIV ● Yes ○ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment — ○ Yes ◉ No

b) Professional Development — ○ Yes ◉ No

c) Coordination of Various Activities and Services — ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://rules.sos.ri.gov/organizations/title/212

If the answer is No to any of the above, please explain the reason.

If we have not identified the area in need of improvement or changes, the "no" box was chosen.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? Yes No

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

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12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

[2] *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues? (●) Yes ( ) No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? (●) Yes ( ) No

3. Does the state provide training on trauma-specific treatment and interventions for M/SUD providers? (●) Yes ( ) No

4. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? (●) Yes ( ) No

5. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ( ) Yes (●) No

6. Does the state use an evidence-based intervention to treat trauma? (●) Yes ( ) No

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

The state has implemented the "Seeking Safety" program statewide to be embedded in community mental health organizations. This training was selected by providers as the most effective method to train clinical staff on trauma.

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

N/A

Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [x] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [x] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [x] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [x] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [x] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

(●) Yes ( ) No

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals has implemented a District Court Diversion program delivered by a licensed behavioral healthcare organization to provide rapid assessment and expedited access to behavioral healthcare services. As designated, clinicians are to be embedded in Rhode Island Courts to provide specific onsite assessments, treatment recommendations, consultations to the court and linkages to resources in the community for clients. Court Clinicians are also to provide behavioral healthcare updates regarding the treatment needs and status of clients to the court. The purpose of this initiative is to identify persons with behavioral health disorders (mental health, substance abuse, and co-occurring disorders), who appear before the District Court, and divert them from the criminal justice system by connecting them with the level of care needed to safely return to a community setting and avoid future criminal justice system involvement
The Co-Response outreach program consists of Community Mental Health behavioral health clinicians working directly with law enforcement officers that provide field-based outreach services in addition to diversion focused interventions or alternatives to law enforcement responses to calls when behavioral health needs are identified.

An inter-agency workgroup has been formed, consisting of representatives from the Executive Office of Health and Human Services, Department of Behavioral Health, Developmental Disabilities, and Hospital, and the Department of Corrections to provide recommendations for improving pathways to care for individuals involved in the justice system.

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

(●) Yes ( ) No

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

One of our Federally qualified Health Centers, Thundermist Health Center, received certification from CIT (Crisis Intervention Training) International for both a regional and statewide Crisis Intervention Team training program. Thundermist launched their first CIT program in 2019. Their work expanded with support from the Rhode Island Police Chiefs Association utilizing funds through the Justice Reinvestment Fund, as well as grant funding through a federal Community Policing Development (CPD) Microgrant. In 2021, BHDDH became a grantee of the SAMHSA Early Diversion grant and entered into an MOU with Thundermist to execute a CIT academy in the Providence area and provide technical assistance as police departments statewide developed their own CIT programs. To date, Thundermist has certified more than 150 sworn police officers statewide in CIT training. In addition, they have engaged nearly 75 dispatchers, telecommunicators, peers and community advocates in specialized CIT trainings. Since June 2021 to date, Thundermist has executed CIT academies that have certified over 180 sworn officers and over 45 personnel that include but are not limited to; Behavioral Health Providers, EMS staff, Fire Department Personnel, Dispatchers, Wardens and Social Workers

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

N/A

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14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds?

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☐ Naltrexone (oral, IM)
- **f)** ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? (●) Yes ( ) No

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

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15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

Rhode Island 's development of a statewide crisis continuum of care has been planned using SAMHSA's "National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit" as a foundation. This includes initial 988 rollout as well as the buildout of the CCBHC model here in the state, currently underway. Together, 988 and CCBHC implementation in Rhode Island will deliver on the "Someone to call, Someone to respond, and Somewhere safe to go" pillars of SAMHSA's vision for integrated crisis services.

Crisis Call Centers: Rhode Island has one 988 Lifeline Center that serves the entire state. It is run by Horizon Healthcare Partners (HHP), and answers 988 Suicide and Crisis Lifeline calls in-state 24/7/365 and answers in-state 988 texts and chats on a limited basis. It also answers calls from the statewide crisis line, 414-LINK, that is operational but no longer actively promoted due to 988 rollout. In addition, HHP staff operate the 942-STOP Hope & Recovery line which provides access to treatment, recovery housing, and supports to Rhode Islanders. They also answer BHDDH's Quality Assurance Hotline (Adult Protective Services) after hours.

Our 988 Lifeline Center has working relationships with other call centers throughout the state, including 211, the Aging and Disability Resource

Center's Point line, the Kids' Link behavioral health triage service and referral network, Coordinated Entry line for emergency shelter needs, and the 24-hour domestic violence helpline operated by Blackstone Valley Advocacy Center.

Mobile Crisis: In 2024 Rhode Island plans to have multiple Certified Community Behavioral Health Centers (CCBHCs) which will provide 24/7/365 mobile crisis to their catchment areas. The goal is to eventually have a CCBHC for each of the 8 designated Rhode Island catchment areas providing this extensive mobile crisis coverage.

Rhode Island Outreach (RIO) sends behavioral health response teams to people experiencing mental health crises. The program is based in Newport County but also has an East Bay team to help with calls from East Providence, Bristol, Warren, and Barrington. RIO works with both 988 and the BH Link triage center.

RI also has mobile crisis liaisons, some of which respond with police, and those that follow-up after an arrest diversion. While CCBHCs are ramping up, the goal is for all CMHCs to have after hour mobile crisis response which will operate statewide.

Crisis Receiving and Stabilization Centers: HHP operates a 24/7 community-based walk-in/drop-off triage facility where clinicians connect people to immediate, stabilizing emergency behavioral health services, and long-term care and recovery supports. The facility is for anyone residing in Rhode Island 18 and older experiencing a BH crisis that may require a MH/SUD assessment, referrals, peer support, recovery support, connection to MAT and/or MH/SUD treatment. Triage center staff work with municipalities and mobile crisis teams to ensure the service is available statewide.

When CCBHCs are fully implemented they will also have open access and same day crisis services.

RI has 10 Emergency Departments with one operating a specialized BH emergency treatment unit.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. *Someone to talk to: Crisis Call Capacity*
    a. *Number of locally based crisis call Centers in state*
        i. *In the 988 Suicide and Crisis lifeline network*
        ii. *Not in the suicide lifeline network*
    b. *Number of Crisis Call Centers with follow up protocols in place*
    c. *Percent of 911 calls that are coded as BH related*
2. *Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)*
    a. *Independent of first responder structures (police, paramedic, fire)*
    b. *Integrated with first responder structures (police, paramedic, fire)*
    c. *Number that employs peers*
3. *Safe place to go or to be:*
    a. *Number of Emergency Departments*
    b. *Number of Emergency Departments that operate a specialized behavioral health component*
    c. *Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☑	☐
Safe place to go or to be	☐	☐	☑	☐	☐	☐

b. Briefly explain your stages of implementation selections here.

a. Someone to talk to
RI's 988 Lifeline Center serves the entire state. Despite significant increases in volume, RI's call answer rates remain in the high 90th percentile and have been there since prior to 988 launch. (See table below.) RI's 988 Lifeline Center currently answers texts and chats to 988 approximately eight hours a week. Though current coverage is statewide, full implementation and program sustainment of "Someone to Call" will be complete when full staffing is in place, texts/chats are answered in-state 24/7/365, and a sustainable funding stream is in place.
b. Someone to respond In 2024, with the rollout of the CCBHCs, 24/7 Statewide mobile crisis will be implemented. Although there is statewide mobile crisis currently, it does not operate 24/7. Implementation stage?
c. Safe place to go or to be Program sustainment and expansion. Currently operating a 24/7 crisis receiving and stabilization triage center. With the implementation of CCBHCs, there will be additional open access and same day crisis services.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

The rollout of the CCBHCs and a 988-dispatch platform will connect all crisis services to ensure statewide response and collaboration. While RI currently has the foundation of a crisis system, the implementation of the additional crisis services and collaboration through the dispatch platform will ensure a 24/7 statewide crisis response.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

All crisis services are included in the set aside calculations which exceeds the 5%. These services include our triage center, BH Link and the Co-responders contract. BH Link is a facility for those in crisis to receive assessment and referral. The agency accepts walk-ins, referrals from other providers and accepts drop offs from 1st responders including police and ambulances. The Co-responders are clinicians who accompany police on calls when there is an indication that there is a mental health crisis.

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

N/A

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16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a)	Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?	(●) Yes	( ) No
b)	Required peer accreditation or certification?	(●) Yes	( ) No
c)	Use Block grant funding of recovery support services?	(●) Yes	( ) No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	(●) Yes	( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Recovery support services for adults with SMI are provided by multiple agencies across Rhode Island. Services available include one on one peer support, peer to peer recovery support groups, recovery education groups, wellness groups, art based groups, and social hours. Services are available in person and virtually.
Recovery services for children with SED are provided a community mental health organization, The Providence Center (TPC). TPC operates The Jim Gillen Center, which is a teen recovery center. Coaching, planning, and support. The Center hours of operation are skewed to allow participants to come after school hours. Seven Challenges also supports children with SED by operating at the Training School for children in custody. The program services dual diagnosed individuals.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

Recovery support services for adults with SUD are provided by multiple agencies across RI, primarily RCCs. Services available include one on one peer support, peer to peer recovery support groups, recovery education groups, wellness groups, art based groups, and social hours. Services are available in person and virtually.

5. Does the state have any activities that it would like to highlight?

In 2022, BHDDH funded a Leadership Fellows Academy (LFA) for leaders with lived experience in RI. The LFA is an innovative 8-month training program that builds leadership capacity at the individual, organization, and community levels to strengthen a state's recovery ecosystem and organizations. The LFA kicked off in July 2022 and concluded in February 2023. Participants gave very positive feedback on the training and evaluations showed that all graduates left the experience with a lot of new knowledge and increased confidence in their ability to achieve positive results in their organizations and communities. This group of graduates has formed an independent peer leadership council that has already started advocating for the changes they believe need to happen to better serve Rhode Islanders in recovery.

In 2022, BHDDH also began covering all credentialing fees for Peer Recovery Specialists (PRS). The second year of this funding began in Spring 2023 and BHDDH hopes to continue covering all credentialing fees for PRS in perpetuity.

In 2022, BHDDH contracted with the RI Certification Board (RICB) to create a Peer Recovery Specialist Supervisor credential. The RICB convened a group of subject matter experts to create a content outline that outlined all necessary knowledge and functions of a CPRS Supervisor and in July 2023, the RICB voted to approve the credential. This credential will start being offered in Summer 2024, pending the availability of CPRS supervisor specific training.

In 2023, BHDDH contracted with C4 Innovations to create and design multiple trainings for Peer Recovery Specialists, starting with the 46 hour base training required for initial PRS credentialing. C4 is currently in the process of developing this 46 hour base training and will move to developing a CPRS supervisor training that aligns with the new RICB CPRS Supervisor credential next. All trainings are developed with significant input from multiple groups of subject matter experts. Train the trainer courses for both trainings mentioned will also be developed and offered free of charge to agencies across RI, with the hope of raising capacity of individual agencies to train and supervise their own PRS.

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

TA on how to support integration of mental health/illness recovery support and SUD recovery support when it makes sense would be very helpful. While RI has an integrated PRS certification, meaning that people in recovery from MI and SUD go for the same training and receive the same credential, there is hesitation in the SUD recovery community about serving people with mental health challenges/mental illness. BHDDH understands there are distinct features to SUD recovery and MH/MI recovery that don't overlap, but we also see there are significant overlaps between these groups. TA on how to bridge the gap between the two recovery communities, through education or other means, would be helpful.

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	○ Yes	◉ No
Home and community-based services	○ Yes	◉ No
Peer support services	◉ Yes	○ No
Employment services.	○ Yes	◉ No

2. Does the state have a plan to transition individuals from hospital to community settings? ◉ Yes ○ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is in the process of implementing several exciting initiatives that address the ADA/Olmstead initiative. These new programs are the result of collaboration with other state agencies whose input has been invaluable.

BHDDH has both state and federal responsibility to ensure that all mental health providers in Rhode Island comply with state and federal requirements and open its group homes to all clients across the state who are in critical need of access to a group home that meets their individual needs. Pursuant to R.I. Gen. Laws § 40.1-5-3(g), entitled General powers and duties of state department of behavioral healthcare, developmental disabilities and hospitals, the director's authority includes the following:

The director may adopt rules and regulations governing the management of facilities, both public and private, as he or she may deem necessary to carry out the provisions of this chapter to insure [sic] the comfort and promote the welfare of the patients.

Through the authority granted to the director of the Department, BHDDH has developed less restrictive alternatives to hospitalization. Priority lists are established and maintained to ensure that every individual in need of mental health residential treatment will access the appropriate level of care in accordance with the Olmstead decision.

What follows are descriptions of recent BHDDH initiatives that address gaps in the continuum of care by expanding services in the community. In addition, the areas of housing, employment and peer support services are also discussed, below. Finally, the state's efforts to formalize its efforts into an Olmstead Plan are also reviewed, below.

A. Enhanced Mental Health Psychiatric Rehabilitative Residences (E-MHPRRs)

To provide the appropriate treatment in the least restrictive setting, the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) has led an initiative to develop psychiatric rehabilitative residences for the most seriously mentally ill individuals, some of whom currently are patients in the state's Eleanor Slater Hospital (ESH) psychiatric units and in community inpatient psychiatric hospitals. The new residences will enable hospitalized individuals who are able to live in the community with necessary supports to transition to this new community setting.

These new Enhanced Mental Health Psychiatric Rehabilitative Residences (E-MHPRRs) are planned for a total of twenty-seven (27) residents whose treatment needs cannot be met within our current residential care system. The new residences, that will each have a maximum of nine (9) residents, will have a higher staff-to-resident ratio than are found in existing psychiatric residences. Residents will receive a wide range of care coordination, treatment, psychiatric rehabilitation, and individual care services in a congregate-care, community setting. The staff of each home will also include a full-time licensed occupational therapist who will facilitate daily activities and assist in developing each client's potential to live more independently.

RI will offer three (3) major categories of residences to meet the needs of anticipated residents: Medically Intensive, Intensive Behavioral, Intensive Forensic Supportive.

Certification Standards have been written, have been approved by the involved state departments, and have been shared with stakeholders. As of this writing, emergency regulations are active and will soon be replaced by permanent regulations that have been vetted by the Office of Regulatory Reform (ORR) and have been posted with the Secretary of State. As part of the detailed review by ORR, a Cost-Benefit Analysis was conducted and approved by ORR, as well.

BHDDH is currently in the planning stages with a provider and there is an anticipated opening of the first E-MHPRR in late 2023.

A new rate was for this residential level of care was approved by CMS in January 2023.

B. Nursing Facility Specialized Psychiatric Units (NFSPUs)

A second exciting initiative is the plan to open nursing facility specialized psychiatric units (NFSPUs). It is anticipated that nursing facilities that become certified to provide a unit will have a maximum of sixteen (16) patients. This concept was developed for individuals who require a nursing facility level of care, who live with serious/serious and persistent mental illness (SMI and SPMI) and for whom traditional nursing homes are not an option. These units will provide a safe and less restrictive environment than a hospital setting for individuals who have complex needs.

Certified NFSPUs will provide planned and integrated medical and behavioral supports through comprehensive, person-centered treatment and care. Services shall include the daily participation of each resident in an active treatment program in accordance with a person-centered treatment plan individualized to the needs of the resident. Part of the person-centered plan is to have as a goal the eventual discharge to a less restrictive setting, when appropriate.

CMS approve a new rate for this service on 2/8/2023, retroactive to 1/1/2023

C. Certified Community Behavioral Health Clinics (CCBHCs)

In partnership with the state's Executive Office of Health and Human Services (EOHHS), the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is in the process of implementing Certified Community Behavioral Health Clinics (CCBHCs). BHDDH and EOHHS have developed a plan to provide a robust statewide continuum of care, including mobile crisis services, that will serve individuals across the lifespan. This initiative is a result of an examination of gaps and shortages in the behavioral healthcare continuum, as well as a commitment to modernizing the behavioral healthcare system as a whole in RI to be consistent with the Substance Abuse and Mental Health Services Administration's (SAMHSA's) best practice guidelines; and strives to resolve programmatic deficits while also addressing the Olmstead mandate.

BHDDH and EOHHS issued Certification Standards that are modeled after federal CCBHC standards issued by SAMHSA. A new payment model is also being implemented that will ensure that that there will be a community behavioral health care delivery system that will provide services regardless of an individual's ability to pay and will enable the CCBHCs to maintain adequate, qualified staff to serve the needs of the population for whom the CCBHC is responsible. BHDDH and EOHHS have devoted innumerable hours of work with the community and potential providers to ensure the success of CCBHCs; in addition, the RI State Legislature has committed significant funding to support CCBHCs.

E. Housing

BHDDH is working collaboratively with Medicaid to educate providers about the new Home Stabilization services that are now reimbursable through Medicaid; additionally, BHDDH serves on the Application Review Committee.

The director of BHDDH serves as a commissioner on the Housing Resource Commission (HRC). BHDDH, through the director or his designee, works to support the HRC's mission is to ensure that all Rhode Islanders have access to safe and affordable housing. The HRC is the state's planning and policy, standards and program agency for housing issues.

BHDDH also works closely with RI Housing, the Department of Housing and the Executive Office of Health and Human Services (EOHHS) to develop and pilot programs to address service needs for individuals with SMI/SPMI to assist them with housing retention. The Department has been very involved with the state's homeless response and continues to serve on the Continuum of

Care (the policy and planning body for the state to address homelessness). Finally, BHDDH works with the public housing authorities to increase access to Mainstream and Housing Choice Vouchers.

F. Supported Employment

BHDDH is committed to ensuring that all individuals receiving behavioral health services are offered supported employment and education services. To accomplish this, BHDDH has hired a dedicated staff to work with behavioral health agencies to support this goal. BHDDH has contracted with the IPS Employment Center to provide IPS (Individual Placement and Support) trainings to all Employment Specialists and their supervisors in all Community Mental Health Centers. Additionally, the Department has initiated a statewide employment task force to bring stakeholders together to ensure supported employment is embedded within treatment. Lastly, IPS will be a required evidenced-based service that will be required in CCBHC.

G. Peer Support Services

Data that has been collected demonstrates that emergency department visits decrease when an individual is assigned to a peer. BHDDH has invested significantly in the training and certification of peer recovery specialists so that peer support can be widely available statewide to those who may benefit from a one-to-one peer relationship. More information on BHDDH's investment in peer support is located in this application in the Recovery section (number 16.)

D. Preparing for an Olmstead Plan

Through the Executive Office of Health and Human Services (EOHHS), a collaboration among state agencies has begun to evaluate the process to move forward to develop and implement a comprehensive Olmstead Plan that will serve individuals across all disabilities and across the lifespan. The State of Rhode Island legislature recently allotted funding to hire support staff who will assist with this initiative. It is anticipated that these new staff members will provide valuable assistance in obtaining significant stakeholder input as the Plan is developed.

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

Any technical assistance related to the development and implementation of a statewide Olmstead Plan across all disabilities and across the lifespan would be appreciated.

BHDDH has worked with providers to prioritize mental health residential placement as is relates to compliance with the Olmstead decision.

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18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[4].

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? ◉ Yes ○ No

b) The resilience of children and youth with SED? ◉ Yes ○ No

c) The recovery of children and youth with SUD? ◉ Yes ○ No

d) The resilience of children and youth with SUD? ◉ Yes ○ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ◉ Yes ○ No

b) Health care? ◉ Yes ○ No

c) Juvenile justice? ◉ Yes ○ No

d) Education? ◉ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ◉ Yes ○ No

b) Costs? ◉ Yes ○ No

c) Outcomes for children and youth services? ◉ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ◉ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ◉ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ◉ Yes ○ No

b) for youth in foster care? ◉ Yes ○ No

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? ◉ Yes ○ No

d) Does the state have an established FEP program? ◉ Yes ○ No

Does the state have an established CHRP program? ◉ Yes ○ No

e) Is the state providing trauma informed care? ◉ Yes ○ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

A system of care is a wide spectrum of effective, community-based services and supports that is organized into a coordinated network. The network is guided by principles laying out the way services and supports are provided to children and families, including interagency collaboration; individualized strengths-based care; cultural competence; child, youth, and family involvement; community-based services; and accountability.
The Executive Office of Health and Human Services (EOHHS) works with other state agencies – the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, the Department of Children, Youth, and Families, the Office of the Health Insurance Commissioner, the Rhode Island Department of Education, and the Rhode Island Department of Health - on continuing planning and implementing Rhode Island's Children's Behavioral Health System of Care. EOHHS engages the statewide community to ensure extensive stakeholder engagement and collaboration during this process. This is inclusive of community providers, community activists, and other interested parties.
This interagency team has created the following workgroups:
1. Crisis continuum, development and access, screening, and assessment
2. Care authorization, care coordination and care monitoring
3. Service array
4. Ensuring equity: race equity, family members, with IDD, and LGBTQ+ Families
5. Workforce transformation
6. Data systems for outcomes measurement and evaluation
7. Community outreach and education
BHDDH has worked collaboratively with the state authority on child's behavioral health (DCYF) for many years. This year, DCYF is reprocuring their array of services and has not submitted a request to BHDDH for funding for services to children with serious emotional disturbance. The prior MOU has expired. BHDDH and DCYF have had several meetings since the Spring to develop a plan for collaboration. At this time, once DCYF has submitted their request, it will be reviewed for approval. BHDDH has expanded services through Healthy Transitions and Seven Challenges to meet the needs of children with serious emotional disturbance. Additionally, EOHHS has implemented children's mobile response to provide crisis services to children with serious emotional disturbance.

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

The Seven Challenges program is throughout the state, including in private practice and the juvenile justice system. Judges are able to refer directly to the program. We have established a system that provides continuity of care and this year have developed a sustainability plan.

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

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19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

Priority 1: Strengthen economic supports
Priority 2: Create protective environments
Priority 3: Improve access to and delivery of care
Priority 4: Promote healthy connections
Priority 5: Teach coping and problem-solving skills
Priority 6: Identify and support people at risk
Priority 7: Lessen harms and prevent future risks
Priority 8: Build Rhode Island's suicide prevention infrastructure

3. Have you incorporated any strategies supportive of Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (●) Yes ( ) No

If yes, please describe how barriers are eliminated.

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.
Goal 1: Intervene after a suicide (postvention)
Goal 2: Report and message about suicide safely

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? ( ) Yes (●) No

If so, please describe the population of focus?

BHDDH has been working with the RI Department of Health (RIDOH) since the beginning of 2023 in the development of the Rhode Island Adult Suicide Strategic Plan and revising the RIDOH Suicide Prevention website . This Plan is now in draft and will be an attachment for this year's SAPT Block Grant application. The website will be completed by December 2023.

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

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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

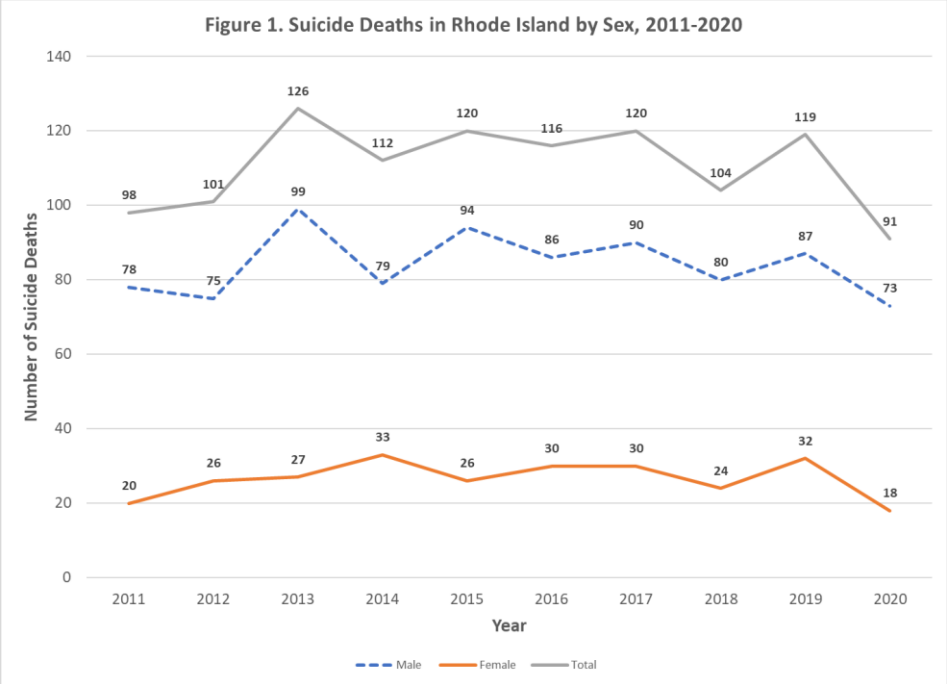
[3] Rhode Island Violent Death Reporting System (RIVDRS), 2011-2020, Suicide deaths that occurred in Rhode Island among Rhode Island residents

[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.

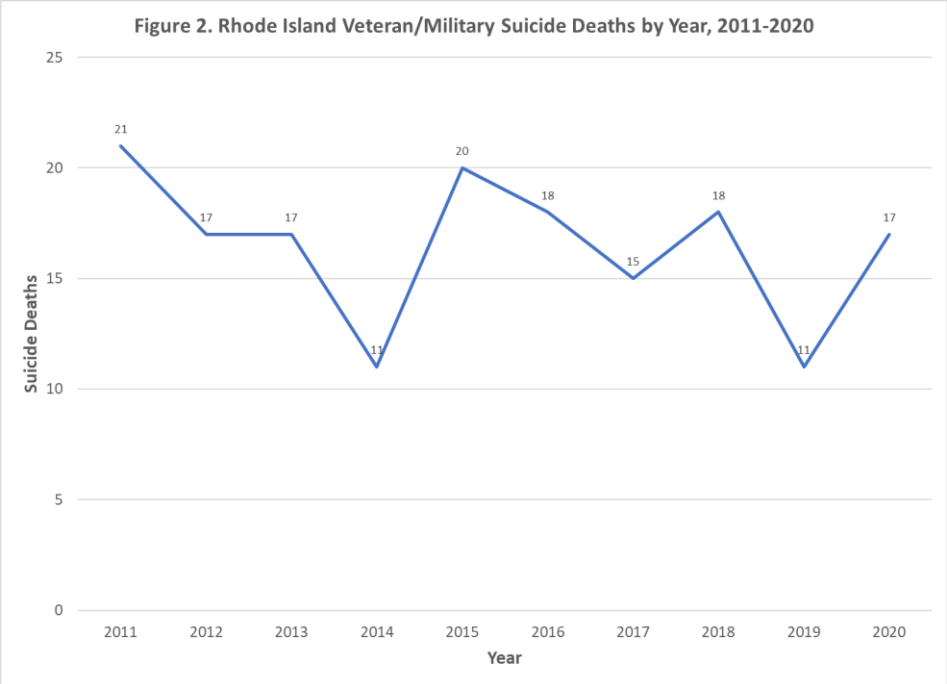
[6] For example, first responders, law enforcement, and construction workers.

- **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

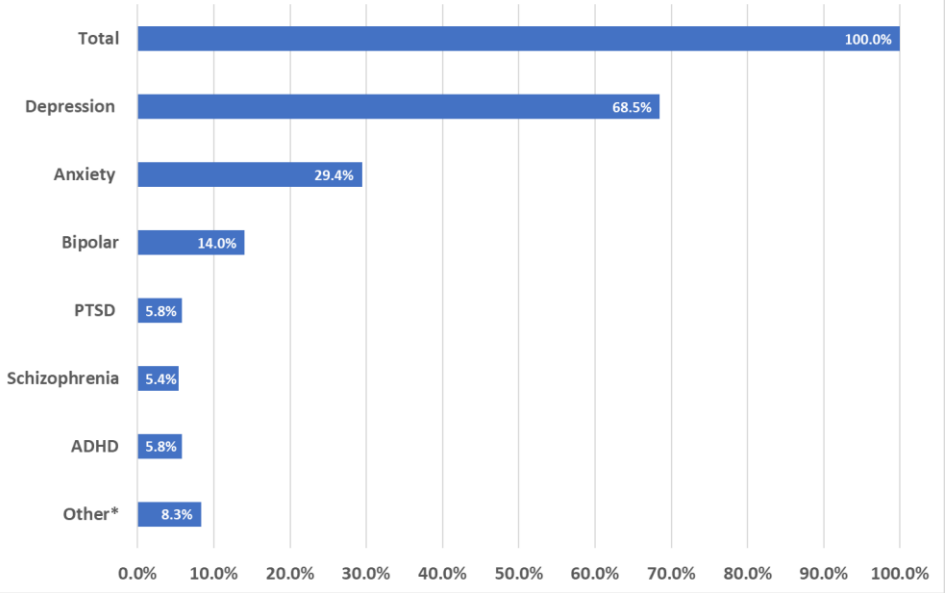
County	Rate per 100,000
Bristol County	12.2
Washington County	11.8
Kent County	11.4
Newport County	11.0
Providence County	9.8

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.

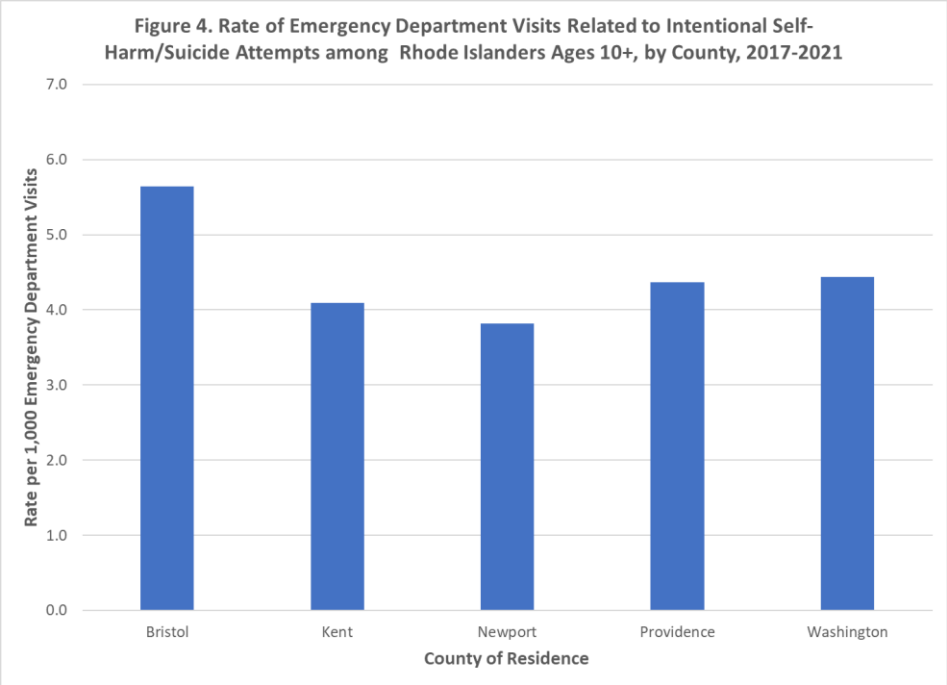
[10] https://www.hsph.harvard.edu/means-matter/means-matter/risk/

[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)

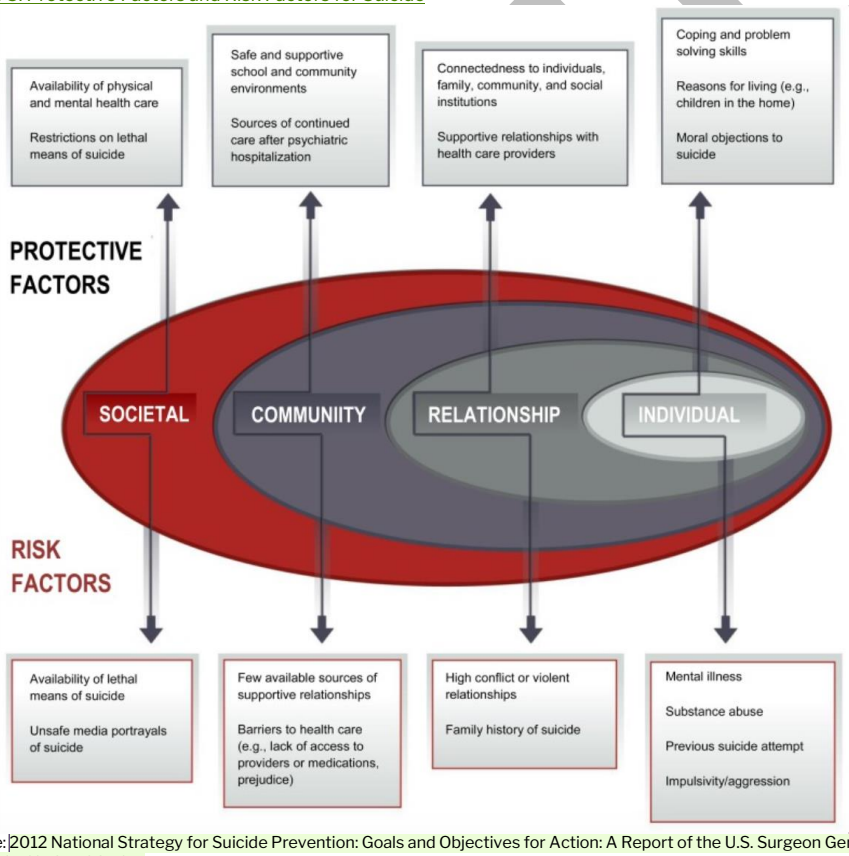
Research-Validated Suicide Factors

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.

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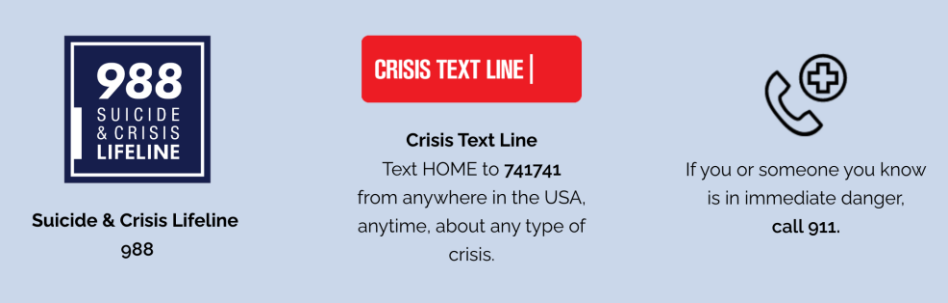

Alliance for Suicide Prevention.

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.

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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.

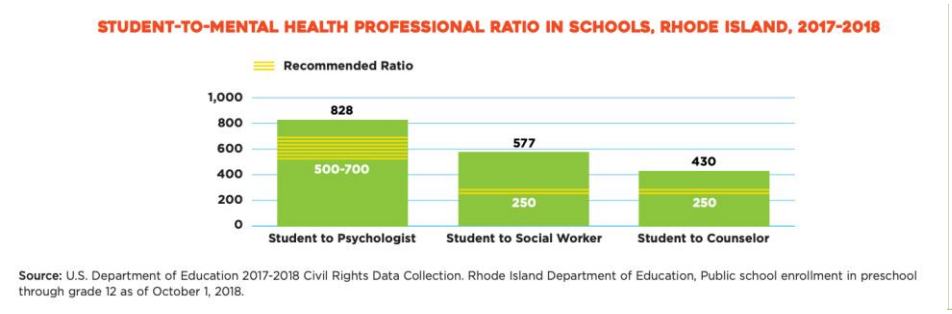
There are also significant workforce shortages of case managers, nurses, peer recovery specialists, and primary care and family physicians who can support mild to moderate mental and behavioral health needs.

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.

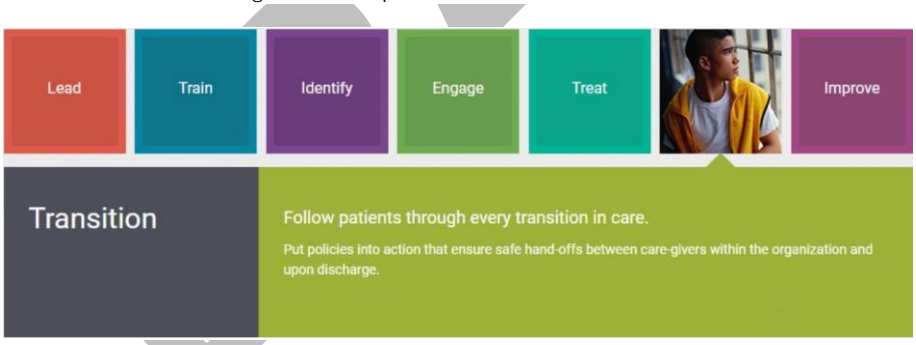
Strategies

- 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
Adriana Briceno M	Community Living Aide	RI Dept of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH)
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)
Margaux Morisseau	Deputy Director	Rhode Island Coalition to End Homelessness
Rachel Morse, MSHS, CPS	Co-Director	Rhode Island Prevention Resource Center (RIPRC)
Weayonnoh Nelson - Davies, J.D.	Executive Director	Rhode Island Economic Progress Institute
Obed Papp	Healthy Communities Office's Program Manager and Regional Coalition Director	City of Providence
John Patton	Founder	Matthew Patton Foundation
Stacy Perin	Associate Director.	The Spurwink School
Marisa Petreccia	Deputy Director	Rhode Island Department of Human Services
James Rajotte	Chief Strategy Officer	Rhode Island Executive Office of Health and Human Services
Kim Rausch	Associate Director of Policy & Program ·	Rhode Island Department of Human Services
Zachary Rega-Oliveira MHA, MSN, PMHNP-BC, NEA-BC	Director, Psychiatric Nursing Services	Rhode Island Hospital & Hasbro Children's Hospital
Gary Regan, LICSW	Clinical Director	Adolescent Partial Hospital and SafeQuest programs, Bradley Hospital
Leigh Reposa	Manager, Youth Suicide Prevention Program	RI Student Assistance Services
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
Lucy Rios	Executive Director	RI Coalition to End Domestic Violence
Candace Rodgers	Lead Administrator of Prevention and Recovery Services	RI Dept of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH)
Alicia Rodriguez	Community Engagement and Partnership coordinator	Providence VA Medical Center
Corrina Roy	Associate Director, Division of Behavioral Healthcare	RI Dept of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH)
Marti Rosenberg	Director of Policy, Planning, and Research	Rhode Island Executive Office of Health and Human Services
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
Emily Spence	Community Champion/ Parent Educator at Parents As Teachers	Bristol County Health Equity Zone/ Bristol-Warren School District
Anthony Spirito	Director, Division of Clinical Psychology	Warren Alpert Medical School of Brown University
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

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

BHDDH established a Systems Review (SR) initiative as an avenue to create partnerships between BHDDH and the full network of community providers. The SR meets, in-person, quarterly in each of the 7 catchment areas, facilitated by each CMHC and two representatives from BHDDH. Each SR will evaluate the services, client flow, and gaps within their designated CMHC catchment area. The SR addresses the comprehensive behavioral health system within its catchment area to include planning, prevention, early intervention, treatment, and recovery support efforts.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

BHDDH meets with state partners on a minimum of monthly intervals. Additional meetings are added when there is contract development, CCBHC tasks, and when there is an identified concern.
The State of Rhode Island establishes services for students with disabilities via EOHHS, the entity that oversees BHDDH. Additionally, BHDDH provides student assistance councilors in 39 high schools which provide screening, prevention and referral services.

RI is currently underway in implementing statewide CCBHCs. The goal is for a CCBHC to be implemented by the end of 2024 in each of the 8 catchment areas of RI. These CCBHC's will provide 24/7, 365 mobile crisis coverage as well as open access capabilities and more robust services to the communities at large, and across the lifespan. Outreach and engagement to the states most vulnerable populations are the target of each CCBHC. RI is currently working with Brandeis on a statewide community needs assessment. Brandeis is working with providers of behavioral health and substance use services in each of the catchment areas, as well as families and persons with lived experience to identify current gaps in service. This community needs assessment will then assist in guiding each CCBHC in targeting these gaps and enhancing services to these populations. Populations of focus include school aged children, justice involved individuals, unhoused, BIPOC and older adults. Goals of the CCBHC are to develop enhanced care coordination agreements with community agencies to create a more comprehensive system of care and a fixed point of responsibility for each catchment area. There will be DCOs (Designated Collaborating Organization) established with neighboring agencies to assist with coordination of care.

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

N/A

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

A comprehensive presentation was delivered on 8/11/23, see attached. Previously, on 2/27/23, an orientation was held for all members of the Council. It was a refresher for standing members and orientation for new members. Council roles, responsibilities and functions were explained in detail. Members questions and concerns were addressed. They were also provided with contact information for the Block Grant Planner and provided the opportunity to have instruction on WebBGAS.
Since the orientation meeting in February 2023, the Council has added an agenda item for periodic updates to ensure block grant discussions are regularly had. Additionally, there are continuing meetings with individual Council members to address their specific areas of concern. This is a new development since the orientation. The block grant planners have met with the new Chair of the Council to discuss revisions of the meeting format to provide a more robust review of the block grant funding.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

Monthly meetings and presentations of the behavioral health system.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Advises, consults with, and makes recommendations to BHDDH

Reviews plans for recommendations and modifications

Advocates for adults and children with serious emotional disturbance and mental illness

Monitors, reviews and evaluates, at least once per year, the allocation and adequacy of mental health services.

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

N/A

Footnotes:

STATE OF RHODE ISLAND

Governor's Council on Behavioral Health
6 Harrington Road
Cranston, RI 02920
Tel: (401) 462-1782
Email: Tia.Micek@bhddh.ri.gov

Governor's Council on Behavioral Health
Thursday, August 10, 2023; 9:00 – 10:30 a.m.
RI Department of Administration
1 Capitol Hill ~ 2nd Floor Conference Room Providence, RI 02908

This is an ***in-person meeting*** for members of the Council (state law provides exceptions for members who have a waiver through the Governor's Commission on Disabilities).

Zoom link:
https://us02web.zoom.us/j/86162274249?pwd=SkZLU2RQS3pua3dFb1hZT1YzZzBZdz09
Meeting ID: 861 6227 4249
Passcode: 871397

Larry Warner/Acting Director Cerbo
Welcome, Motion for Approval and Vote on June's Meeting Minutes (5 minutes)

Presentations and Discussion
Block Grant Data Presentation – Donna Rook (30 minutes)

Center for Prevention Programs and Partnerships (CP3) 101
Overview Brief – Robert Mahoney (20 minutes)

Committee Updates (10 minutes)
- Olmstead – Laurie-Marie Pisciotta
- Prevention - Sandra DelSesto

Department Updates (10 minutes)
- BHDDH – Thomas Martin
- RIDOH – Kristine Campagna
- OHHS – Marti Rosenberg
- DCYF - Chris Strnad
- OHA - Michelle Szylin

Closing Comments/Announcements (15 minutes)

Next Meeting: Thursday, September 14, 2023 at 9:00 a.m.

Meetings are open to the public. If you plan on attending and require special accommodation, please contact the Division of Behavioral Health Services at 401-462-5686.

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Kevin Aucoin	State Employees		RI,	kevin.aucoin@dcyf.ri.gov
Dennis Bailor	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		RI,	d.bailer562@gmail.com
Utpala Bandi	State Employees		RI,	utpala.bandi@health.ri.gov
Tara Boulais	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		RI,	tarab0778@icloud.com
Linda Bryan	Parents of children with SED		RI,	lindadee76@icloud.com
Kathleen Calandra	Others (Advocates who are not State employees or providers)		RI,	kcalandra@healthcentricsadvisors.org
Megan Clingham	State Employees		RI,	megan.clingham@doa.ri.gov
Maria Crimini	State Employees		RI,	maria.crimini@oha.ri.gov
Sandra Del Sesto	Others (Advocates who are not State employees or providers)		RI,	sandrapdelsesto@gmail.com
Sarah Dinklage	Providers		RI,	sdinklage@risas.org
Christine Gadbois	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		RI,	cgadbois@carelinkri.org
Lindsey Garcia	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		RI,	lindsay_garcia@brown.edu
Inez Garcia	Parents of children with SED		RI,	igarcia@ebcap.org
Michael Hogan	State Employees		RI,	michael.hogan@doc.ri.gov

Margaret Holland McDuff	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		RI,	mhmcduff@familyserviceri.org
Linda Hurley	Others (Advocates who are not State employees or providers)		RI,	lhurley@codacinc.org
Angelica Infante -Green	State Employees		RI,	angelica.green@ride.ri.gov
Ian Knowles	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		RI,	iknowles@recares.org
Ian Lacombe	Others (Advocates who are not State employees or providers)		RI,	ilacombe@butler.org
Rich Leclerc	Others (Advocates who are not State employees or providers)		RI,	richleclerc@gmail.com
Wendy Looker	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		RI,	arcs2995@gmail.com
Jason Lyons	State Employees		RI,	jason.lyons@ohhs.ri.gov
Tom Martin	State Employees		RI,	thomas.martin@bhddh.ri.gov
James McNulty	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		RI,	jmcnultyri@gmail.com
Kate Medeiros	State Employees		RI,	katelyn.medeiros@doa.ri.gov
Peter Neronha	State Employees		4 Howard Ave Cranston RI, 02920	
George O'Toole	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		RI,	gotoole@ebcap.org
Teresa Paiva Weed	Others (Advocates who are not State employees or providers)		RI,	Tpaiva@hari.org
Oded Papp	Providers		RI,	opapp@providenceri.gov
Esther Picone	Parents of children with SED		RI,	e.picon@pshri.org
Laurie Pisciotta	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		RI,	LMPisciotta@gmail.com
Ronald Racine	State Employees		57 Howard Avenue Cranston RI, 02920	
Janet Spinelli	Others (Advocates who are not State employees or providers)		RI,	janetspin@aol.com
John Tassoni	Others (Advocates who are not State employees or providers)		RI,	jtassoni@sumhlc.org

Mike Tondra	State Employees		One Capital Hill Providence RI, 02908	
Larry Warner	Others (Advocates who are not State employees or providers)		RI,	Larry.Warner@unitedwayri.org

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

A representative from the State Social Services will be assigned within the next few weeks, as there are current discussions. 11/2/23

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	10	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	0	
Parents of children with SED	3	
Vacancies (individual & family members)	0	
Others (Advocates who are not State employees or providers)	9	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**22**	**61.11%**
State Employees	12	
Providers	2	
Vacancies	0	
Total State Employees & Providers	**14**	**38.89%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	4	
Individuals/Family Members from LGBTQI+ Populations	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**40**	

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Footnotes:

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22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? (●) Yes ( ) No

If yes, provide URL:

https://bhddh.ri.gov/mental-health/governors-council-behavioral-health

Link to meeting at Govenor's Council that discussed the state plan: https://opengov.sos.ri.gov/Common/DownloadMeetingFiles?FilePath=\Minutes\1358\2023\472399.pdf

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://bhddh.ri.gov/mental-health/governors-council-behavioral-health

Link to the state plan: https://bhddh.ri.gov/substance-useaddiction/block-grant-information

c) Other (e.g. public service announcements, print media) ( ) Yes (●) No

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

N/A

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Footnotes:

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

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

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

Rhode Island does not plan to use funding for syringe services.

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Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

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

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes:

Rhode Island is not using funds for syringe services.