Rhode Island

UNIFORM APPLICATION
FY 2026/2027 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 09/02/2025 7.35.29 AM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

and

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

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State SUPTRS BG Unique Entity Identification

Unique Entity ID	LWPVXFL8DS51

I. State Agency to be the SUPTRS BG 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 SUPTRS BG Grantee of the Block Grant

First Name	Richard
Last Name	Leclerc
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	rich.leclerc@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	Richard
Last Name	Leclerc
Agency Name	Rhode Island Department of Behavioral Healthcare, Developmental Disabilties and Hospitals
Mailing Address	14 Harrington Road
City	Cranston
Zip Code	02920
Telephone	(401) 462-2339
Fax	
Email Address	rich.leclerc@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	8/28/2025 3:06:14 PM
Revision Date	8/28/2025 3:07:06 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: 05/28/2025 Expires: 01/31/2028

Footnotes:

State: Rhode Island
Grant: Block Grants for Community Mental Health Services
Project: Bipartisan Safer Communities Act (BSCA)
Project Period: 09/30/2024 - 09/29/2026
Total Allowable Budget: **$205,329**

1. Rhode Island will be using the BSCA funds to continue to support the Traumatic Response Team (TRT). TRT was developed in 2023 utilizing BSCA funds to create the program.
    a. A traumatic event exasperates those individuals with currently existing issues such as serious emotional disturbance, serious mental illness, entanglement in the criminal justice system, and those with insecurities such as housing and basic needs.
    b. Rhode Island Medical Reserve Corps (RIMRC) is responsible for dispatching the TRT. RIMRC and TRT maintain collaborative relationships with all involved parties; schools, law enforcement, emergency responders and behavioral health organizations, including 988 Lifeline, and all other mobile crisis response programs.
    c. TRT has a cadre of highly qualified traumatic incident response volunteers, recruited from professional settings. The volunteers are properly prepared to function in an emergency crisis developing from a traumatic event and function within the Federal Emergency Management Agency (FEMA) command incident model. The highly trained volunteers would be dispatched to respond 24/7 to the site of the traumatic event along with first responders.
    d. The purpose for the response is to minimize the effects of the traumatic event for the individual and families involved by providing mental health crisis support. The respondent skills will be specific to trauma (gun violence, suicide, fatality, etc.), addressing children and families in crisis, and identification of children with serious emotional disturbance and the referral process.
    e. The goal of TRT is to address the need for mental health services in the aftermath of traumatic events in the communities. TRT fills a crucial gap of providing mental services on the scene of a traumatic event, especially targeting those with complex presentations.
    f. The trainings provided will enhance the skills and knowledge of the behavioral health community by providing specific training on trauma to staffing of the community behavioral health organizations. The developed trainings will contain modules on identification of existing mental illness, emotional disturbances, basic needs and how to link the individuals and families to needed resources.

2. Rhode Island will be using the 10% ESMI set aside requirement on Coordinated Specialty Care.
    a. The funding will be used to implement evidenced-based Coordinated Specialty Care programs at two competitively selected CCBHCs with existing young adult

programs that provide the ACT service provision but lack specialized CSC programming tailored to FEP.

3. Rhode Island will be using the 5% Crisis set aside requirement on 988 Lifeline Center.
    a. Horizon Healthcare Partners shall operate a statewide 24/7/365 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.

Category	**Total Proposed Cost**
Personnel	$0
Fringe	$0
Travel	$0
Equipment	$0
Supplies	$0
Contractual	$205,329
Total Direct Costs	$205,329
Total Indirect Costs	$0
Total Project Costs	**$205,329**

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 **$205,329**

- Traumatic Response Team: **$172,723.40**
- Coordinated Specialty Care **$22,339.15** (10% ESMI required set-aside)
- 988 Lifeline Center: **$10,266.45** (5% Crisis required set-aside)

Total Direct Charges:	**$205,329**
Indirect Charges:	**$0**
• No requested funds	
Total Project Costs:	**$205,329**

State Information

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

Fiscal Year 2026

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
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Section 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: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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Funding Agreements
as required by
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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.

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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.

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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.

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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)
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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: Richard H. Lecleir

Signature of CEO or Designee[1]:

Title: Director Date Signed: 6/16/25

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: 05/28/2025 | Expires: 01/31/2028

STATE OF RHODE ISLAND

OFFICE OF GOVERNOR DANIEL J. MCKEE

April 4, 2024

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 Director Richard Leclerc, my designee, is authorized to sign any required documents for all federal grants related to BHDDH during his tenure as 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 2026

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 II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**

Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

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.
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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.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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

Title XIX Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grant 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 U.S.C. 300x-9
Section 1920	Crisis Services	42 U.S.C. 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).

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.

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Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, 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: Richard H Lecluse

Signature of CEO or Designee[1]:

Title: Director Date Signed: 6/16/2025
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: 05/28/2025 Expires: 01/31/2028

Footnotes:

STATE OF RHODE ISLAND

OFFICE OF GOVERNOR DANIEL J. MCKEE

April 4, 2024

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 Director Richard Leclerc, my designee, is authorized to sign any required documents for all federal grants related to BHDDH during his tenure as Director of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals.

Sincerely,

Daniel J. McKee
Governor

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

Richard Leclerc

Title

Director

Organization

Behavioral Healthcare, Developmental Disabilities, and Hospitals

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Form is not needed for RI due to the fact that there are 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 prevention system (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 behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. 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."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

RI Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) is the second largest department in the state. The department has four divisions consisting of Behavioral Health, Developmental Disabilities, Forensics, and two State Hospitals. BHDDH ensures 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 is responsible for Block Grant funds across all ages which involves carrying out plans for providing comprehensive community mental health services along with planning, implementing, and evaluating activities that prevent and treat substance use.

BHDDH's Substance Misuse Prevention Strategic Plan sets the goals, objective, and strategies to strengthen primary substance misuse prevention within RI. The goals are 1.) Expand public awareness of the positive impact of substance misuse prevention, recognize the vital importance of it, and secure dedicated state funding to support it, 2.) Improve coordination among statewide prevention funders and providers to avoid duplication of services and effectively leverage all available funding streams to support community-based prevention efforts, 3.) Expand the use of prevention science and evidence-based proactive to guide programmatic and funding priorities.

RI Department of Youth, Children, and Families (DCYF) is the state child welfare, children's mental health, and juvenile corrections services agency which promotes safety, permanence, and well-being of children through partnerships with family, community, and government. DCYF's mission is to build a system of care where every child grows up in a safe and loving family environment that supports the development of strong, resilient families throughout the state of RI. The DCYF Strategic Plan is anchored in four core pillars – Prevention, Accountability, Collaboration, and Engagement (P.A.C.E.).

RI Executive Office of Health and Human Services (EOHHS) serves as "the principal agency of the executive branch of state government" responsible for managing the departments of: Health (RIDOH); Human Services (DHS); Office of Healthy Aging (OHA); Office of Veteran Services (VETS); DCYF; and BHDDH. EOHHS is designated as the single State agency to administer the Medicaid program in RI. EOHHS's mission is to foster and strengthen a community-driven, equitable, comprehensive, responsive, and high-quality health and human services system in RI. EOHHS's Strategic Plan focuses on advancing outcomes, increasing accountability, and stabilizing systems through planning. There are a variety of state meetings that involve collaboration, development, and implementation of strategic plans or programming to improve behavioral health services in the state along with workgroups, committees, and task forces.

RIDOH's mission is to prevent disease and protect and promote the health and safety of the people of RI. RIDOH's Strategic Plan involves the following strategies 1.) promote healthy living for all through all stages of life, 2.) ensure access to safe food, water, and healthy environment in all communities, 3.) promote a comprehensive health system that a person can navigate, access, and afford, 4.) prevent, investigate, control, and eliminate health hazards and emergent threats, 5.) analyze and communicate data to improve the public's health. RIDOH is responsible for professional licensure—including social workers, mental health counselors, chemical dependency professionals—and regulates public health functions such as emergency preparedness, environmental health, and disease surveillance.

DHS is an agency committed to access and achievement, the vision is that all Rhode Islanders have the opportunity to thrive at home, work, and in the community. DHS's programs and services are all designed to help families become strong, productive, healthy and independent; to help adults achieve their maximum potential; to ensure that children are safe, healthy, ready to learn, and able to reach their maximum potential; to honor, employ, and care for our state's veterans; and to assist elderly and persons with disabilities to enhance their quality of life, and to sustain their independence.

OHA is RI's designated state unit on aging, that connects people to information and resources in the community to help them live

happily and healthfully along with advocating for laws, policies, and investments that protect peoples' rights. OHA's Strategic Plan is a blueprint for action to strengthen organizational operations and program offering. It is organized by the following strategic pillars – Choice, Connection, Equity, Safety, and Performance.

VETS remains committed to ensuring that Veterans and their families are care for and receiving the benefits they deserve. VETS works closely with the VA Regional Office and the VA Medical Centers to ensure coordinated care and services.

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

BHDDH is recognized by the federal and state governments as the State Mental Health Authority (SMHA) for adults, the Single State Authority (SSA) for all ages for Substance Use Disorder Treatment and Prevention, and the State Opioid Treatment Authority (SOTA).

BHDDH acts in conjunction with EOHHS as the state's co-designated agency for purposes of the calculation of the expenditures relative to the SUPTRS BG and federal funding maintenance of efforts. BHDDH retains its role as the SSA responsible for planning, coordination, management, implementation, and reporting as required by the SUPTRS BG.

BHDDH's core responsibilities include mental health service system leadership, service implementation and oversight, substance use services authority, prevention and epidemiological planning, recovery initiatives, and transition support.

DCYF is the SSA for children's mental health only. DCYF leads a range of child and youth services—including foster care and juvenile justice—and partners with BHDDH to deliver behavioral health support to children in state care.

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

BHDDH administers and coordinates services through partnerships with state agencies, nonprofit organizations, healthcare providers, and community-based organizations. BHDDH coordinates the planning, funding, and monitoring of public behavioral health services and works in collaboration with state departments listed above, Medicaid Managed Care Organizations (MCOs), Certified Community Behavioral Health Clinics (CCBHCs), and Community Mental Health Clinic (CMHCs).

Service delivery for mental health and substance use is organized regionally by catchment areas served by contracted providers which cover eight pre-determined geographic areas. Individuals seeking services are free to select a provider of their choice and aren't restricted to the area where they reside. The MHBG and SUPTRS BG priority populations are provided services throughout the catchment areas.

Overall, Rhode Island's behavioral health system relies heavily on a network of regionally organized CCBHCs. These CCBHCs serve designated catchment areas and currently cover 90% of Rhode Island and all but one catchment area. The remaining 10% is covered by a CMHC and the state's triage center is in this area. The CCBHCs are complemented by community health centers, tribal and island-specific providers, community coalitions, and school-based supports. These combined efforts aim to deliver accessible, localized mental health and substance use services across diverse populations and geographies.

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Footnotes:

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of 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 should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, 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, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

The RI Block Grant Needs Assessment (BGNA) evaluates the state's mental health and substance use services and barriers to services through secondary data analyses, a community survey, focus groups, and key informant interviews with stakeholders. The needs assessment involves qualitative and quantitative data collection from receivers, providers, family members, and those that aren't receivers of services. The BGNA is presented to the Governor's Council for Behavioral Health which is comprised of public members, providers, and state employees.

The RI State Epidemiological Outcomes Workgroup (SEOW) is comprised of members from RI Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), RI Department of Health (RIDOH), Brown University, Johnson & Wales University, and the University of Rhode Island. The SEOW has conducted the RI Student Survey (RISS) and the RI Young Adult Survey in 2024 and published its findings on the seow.ri.gov website. Additionally, the SEOW posted an interactive dashboard with RISS data on their website. The state uses the RISS to plan for school-based prevention services.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

Based on the findings from the Block Grant Needs Assessment, the recommendations regarding the unmet service needs and critical gaps were: 1.) Increase community-based services and in-home behavioral health services for children and older adults, 2.)

Increase reimbursement rates for primary care providers, 3.) Address staffing shortages and burnout, 4.) Address the surrounding social determinants of health, including housing and food insecurity, 5.) Address stigma and trust in the therapeutic relationships and surrounding behavioral health services. The populations served fall within these five recommendations.

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

The state plans to address the unmet service needs and gaps identified in the needs assessment through implementation of the below funded programs respective to the Block Grants which provide services to the required priority populations.

1. Increase community-based services and in-home behavioral health services for children and older adults.
• The Rhode Island Student Assistance Program (RISAS) provides evidence-based practices in middle and high school and communities to prevent substance use and promote mental health. RISAS is a Recovery Friendly Workplace that focuses on primary prevention (PP) services.
• BH Link is RI's triage center for mental health and substance use crisis which provides services or referrals to the adult priority populations of the Block Grants.
• The Intercept Program is an in-home parenting skills program used to safely prevent children from entering out-of-home care or to reunify them with their families. The Block Grant portion of this program services children with serious emotional disturbance (SED). This program involves a MOU with RI Department of Children, Youth, and Families (DCYF).
• Coordinated Specialty Care is evidence-based treatment designed for first episode psychosis.
• Emergency Respite provides respite beds that are available for individuals whose insurance doesn't cover admission until they're connect with other supports or are stabilized. Emergency Respite beds provide services to adults with serious mental illness (SMI). There are two providers that currently provide these services.
• Substance Exposed Newborns (SEN) supports improving the health and well-being of women who use substances and their substance exposed newborns through referrals to First Connections along with involvement from a Street Medicine Nurse Case Manager. SEN focuses on pregnant women and women with dependent children (PWWDC). This program involves a MOU with RIDOH
• Substance Use Disorder Residential programs provide funding for treatment for substance use for uninsured or underinsured to the priority populations. There are eight providers and ten locations providers that currently provide these services.
• Recovery Community Centers provide peer recovery services, organize recovery activities, and provide education and outreach programs throughout the state to the substance use populations. There are five providers that currently provide these services.

2. Address staffing shortages and burnout.
• There is a training and technical assistance vendor that provides trainings for certifications and licensure in mental health and substance use. This vendor provides peer training development and implementation to become a Certified Peer Recovery Specialist (CPRS). The vendor also conducts Independent Peer Review (IPR) monthly meetings where clinical supervisors from around the state receive group supervision.
• There is a training and technical assistance vendor that provides training and technical assistance to the Regional Prevention Task Forces and RI Student Assistance Services (RISAS) based on a needs assessment which focuses on primary prevention (PP) services.
• RICARES provides advocacy and support to PRS and CPRS who provide recovery support services throughout the state.
• CCBHC training is based on Demonstration Year 2 certification standards and will be for one year.
• Seeking Safety and Creating Change training focuses on evidence-based training for past and present trauma for adults with SMI.
• Prevention Data System is the data collection, management, and reporting system for all prevention providers.
• Seven Challenges Fidelity involves the license fee and continued training in Adult Seven Challenges which is substance use focused.

3. Address the surrounding social determinants of health, including housing and food insecurity.
• Wave Cards provides transportation options to individuals who are reentering the community from prison to attend mental health and/or substance use services and activities that support their recovery and successful reentry. This program involves a MOU with RI Department of Corrections (DOC).
• Mental Health Association advocates to support improved mental health services and increase public awareness for children, adolescence, and adults.
• Recovery Community Centers provide peer recovery services, organize recovery activities, and provide education and outreach programs throughout the state to the substance use populations. There are five providers that currently provide these services.
• RI Student Survey (RISS) examines risk and prevalence of substance use, bullying, depression, suicide, and violence among middle and high schools which is a primary prevention (PP) service.
• The Synar Survey is an assessment of the State's enforcement program conducted with youth participants who attempt to purchase tobacco products.
• Recovery House Certification oversees the recovery house certification based on the current National Alliance for Recovery Residences (NARR) Levels for the substance use populations.

4. Address stigma and trust in the therapeutic relationship and surrounding behavioral health services.

• 988 is the state's 24/7 suicide and crisis lifeline for all ages. People can call, text, or chat for themselves or if they are worried about someone who may need crisis support.

• NAMI raises awareness about mental illness and provides education, training, and support programs for individuals, family members, and the public.

• Regional Prevention Task Forces are response for overseeing the planning and delivery of substance use prevention activities. There are seven providers that currently provide these services.

• Recovery House Complaint Line oversees the complaints from recovery house residents for the substance use populations.

• Recovery House Certification oversees the recovery house certification based on the current National Alliance for Recovery Residences (NARR) Levels for the substance use populations.

• 942-STOP is the line to contact for state funded financial support and placements in recovery housing for the substance use populations.

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Footnotes:

Planning Tables

Table 1: Priority Area 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, 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 middle schools and high schools across 32 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). Additionally, the state's seven regional prevention task forces, which includes regional coalitions working within their communities, will implement the 6 CSAP strategies.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the percentage of youth ages 12-17 reporting perception of risk of harm associated with use of alcohol, marijuana, and ENDS

Baseline measurement (Initial data collected prior to and during 2026): Measured by the 2024 Rhode Island Student Survey (RISS): Alcohol: 44.8%; Marijuana: 52.2%; ENDS: 64.1%

First-year target/outcome measurement (Progress to the end of 2026): Maintain the percentages of perception of risk of harm from the 2024 RISS

Second-year target/outcome measurement (Final to the end of 2027): Increase in perception of risk of harm by at least 2 percentage points as measured by the 2026 RISS: Alcohol: 46.8%; Marijuana: 54.2%; ENDS: 66.1%

Data Source:

Rhode Island Student Survey (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:

N/A

Indicator #: 2

Indicator: Reduce the percentage of youth ages 12-17 reporting 30-day use of alcohol, marijuana, and ENDS

Baseline measurement (Initial data collected prior to and during 2026): Measured by the 2024 Rhode Island Student Survey (RISS): Alcohol: 7.0%, Marijuana: 9.1%; ENDS: 6.3%

First-year target/outcome measurement (Progress to the end of 2026): Maintain the percentages of 30-day use from the 2024 RISS

Second-year target/outcome measurement (Final to the end of 2027): Decrease in past 30-day use as measured by the 2026 RISS: Alcohol: 6.5%; Marijuana: 8.6%; ENDS: 5.8%

Data Source:

Rhode Island Student Survey (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:

N/A

Priority #: 2

Priority Area: Person Who Inject Drugs

Priority Type: SUT, SUR

Population(s): PWID, PRSUD

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:

Rhode Island will continue to provide outreach services in various settings within the area served through the Recovery Community Centers. Recovery Community Centers provide peer recovery services, organize recovery activities, and provide education and outreach programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of total contacts who met with a peer recovery specialist through an RCC Emergency Department program

Baseline measurement (Initial data collected prior to and during 2026): 947

First-year target/outcome measurement (Progress to the end of 2026): 1,150

Second-year target/outcome measurement (Final to the end of 2027): 1,300

Data Source:

Recovery Community Center reporting to the BHDDH Contract Monitoring Unit

Description of Data:

Data will be submitted monthly by the Recovery Community Centers, as part of their contracts. It will be aggregated to an annual total for reporting.

Data issues/caveats that affect outcome measures:

This may include a duplicate count of contacts, as it is not indicated as a unique contact.

Indicator #: 2

Indicator: Number of persons in need of support (ex. seeking treatment, overdosing, homeless, etc.) who receive outreach by peer recovery specialists through an RCC program

Baseline measurement (Initial data collected prior to and during 2026): 37,119

First-year target/outcome measurement (Progress to the end of 2026): 39,000

Second-year target/outcome measurement (Final to the end of 2027): 1,500

Data Source:

Recovery Community Center reporting to the BHDDH Contract Monitoring Unit

Description of Data:

Data will be submitted monthly by the Recovery Community Center, as part of their contracts It will be aggregated to an annual total for reporting.

Data issues/caveats that affect outcome measures:

This may include a duplicate count of people, as it is 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 providers are being monitored to ensure they remained housed.

Strategies to attain the goal:

Ensure providers review the "Residential Arrangement" field in the data collection form (BHOLD). Ensure providers engage individuals in supportive services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of individuals experiencing SMI who are receiving services from behavioral health providers will remain housed

Baseline measurement (Initial data collected prior to and during 2026): 87.8%

First-year target/outcome measurement (Progress to the end of 2026): 88%

Second-year target/outcome measurement (Final to the end of 2027): 90%

Data Source:

BHOLD (Behavioral Health On-Line Data) Collection Form

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 latter categories will not increase, while the percentages in the housed categories will remain stable or increase.

Data issues/caveats that affect outcome measures:

The providers will need to be cognizant of the data fields and the need to update the information. If there is no change in residential arrangement, it is unclear if the provider reviewed housing concerns with the client and/or updated the information in BHOLD.

Priority #: 4

Priority Area: Youth and 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 to and are receiving behavioral health services.

Strategies to attain the goal:

The ACT-YA program will provide wraparound services to youth and young adults, ages 15 to 26, located at the CCBHCs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth and young adults ages 15 through 26 enrolled in treatment services through the ACT-YA Program.

Baseline measurement (Initial data collected prior to and during 2026): 528

First-year target/outcome measurement (Progress to the end of 2026): 538

Second-year target/outcome measurement (Final to the end of 2027): 548

Data Source:

BHOLD (Behavioral Health On-Line Data) Collection Form

Description of Data:

BHDDH collects data via an electronic system that providers enter data into directly.

Data issues/caveats that affect outcome measures:

The providers will need to be cognizant of the data fields when entering the client information.

Priority #: 5

Priority Area: Adults Diagnosed with Serious Mental Illness

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Reduce hospitalization use by Community Support Programs (CSP) clients ie. CSP/ACT/ICTT/IHH

Strategies to attain the goal:

Provider attendance at monthly CCBHC meetings along with DCO agreements between CCBHCs and hospitals.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Rate of CSP clients being re-admitted to hospitals within 30 days of previous admission per 1,000

Baseline measurement (Initial data collected prior to and during 2026): 230 readmits per 1,000 clients

First-year target/outcome measurement (Progress to the end of 2026): Less than 223 readmits per 1,000 clients

Second-year target/outcome measurement (Final to the end of 2027): Less than 216 readmits per 1,000 clients

Data Source:

Medicaid Management Information System (MMIS)

Description of Data:

Medicaid claims data for CSP clients

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 (Initial data collected prior to and during 2026): 82 psychiatric admits per 1,000 clients

First-year target/outcome measurement (Progress to the end of 2026): Less than 80 psychiatric admits per 1,000 clients

Second-year target/outcome measurement (Final to the end of 2027): Less than 77 psychiatric admits per 1,000 clients

Data Source:

Medicaid Management Information System (MMIS)

Description of Data:

Medicaid claims data for CSP clients

Data issues/caveats that affect outcome measures:

Data aligns with the MACPRO (CMS) reporting which is based on the calendar year.

Priority #: 6

Priority Area: Women and Children

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

Improve the health and well-being of perinatal women who use substances and their substance exposed newborns.

Strategies to attain the goal:

The First Connections agencies will outreach substance exposed newborns who have been referred to First Connections and deliver care coordination activities when appropriate Care coordination activities involve connecting the family to resources, i.e., long-term family visiting programs, medical care, WIC, substance use services, mental health services, etc.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of SENs discharged from the hospital for whom First Connections made at least one attempt to outreach

Baseline measurement (Initial data collected prior to and during 2026): 900

First-year target/outcome measurement (Progress to the end of 2026): 950

Second-year target/outcome measurement (Final to the end of 2027): 1,000

Data Source:

KIDSNET, RI's secure children's health database

Description of Data:

RI Department of Health submits monthly data to BHDDH

Data issues/caveats that affect outcome measures:

N/A

Indicator #: 2

Indicator: Number of SENs for whom First Connections provided care coordination activities

Baseline measurement (Initial data collected prior to and during 2026): 100

First-year target/outcome measurement (Progress to the end of 2026): 100

Second-year target/outcome measurement (Final to the end of 2027): 105

Data Source:

KIDSNET, RI's secure children's health database

Description of Data:

RI Department of Health submits monthly data to BHDDH

Data issues/caveats that affect outcome measures:

Care coordination activities may be declined, as this is a voluntary program, and/or not required.

Priority #: 7

Priority Area: 988

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

Ensure Rhode Islanders have 24/7/365 "someone to call" access to trained crisis counselors who will de-escalate behavioral health crises, provide emotional support, connect to community resources, refer to higher level of services and provide follow-up as needed.

Strategies to attain the goal:

Educate individuals on 988, how to contact, and what to expect, through community outreach, media engagement, and public awareness efforts. Implement recruiting and retention activities designed to ensure adequate call center staffing needed to maintain 24/7/365 call coverage and follow-up. Build, update, and execute a best-practice training curriculum for crisis counselors.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of calls answered by the 988-call center

Baseline measurement (Initial data collected prior to and during 2026): 21,923

First-year target/outcome measurement (Progress to the end of 2026): 22,800

Second-year target/outcome measurement (Final to the end of 2027): 24,000

Data Source:

Call log data, shared with the state monthly by the call center

Description of Data:

The total number of calls the RI call center answers and documents during the specified time period. This includes 988 and 414-LINK, which is BH Link's crisis and information line. BH Link is Rhode Island's walk-in crisis stabilization center. Calls from both lines go to our 988-call center and are answered by the crisis counselors; thus, reporting on both lines gives an accurate picture of the call center volume as a whole. Crisis counselors enter the data, data entry assistant shares raw data with the evaluator at BHDDH which is analyzed and reported on.

Data issues/caveats that affect outcome measures:

We also receive 988 data from Vibrant, the national administrator for 988. They provide us logistical data such as number of calls routed and answered. While we often use Vibrant data for public reporting, they do not provide data for 414-LINK. For this reason, we will use call log data for this report. The difference in these two data sources would be the raw number of calls coming into the call center (Vibrant) versus the number of calls documented by crisis counselors (call logs).

Indicator #: 2

Indicator: Proportion of calls resolved over the phone

Baseline measurement (Initial data collected prior to and during 2026): 95.3%

First-year target/outcome measurement (Progress to the end of 2026): 96%

Second-year target/outcome measurement (Final to the end of 2027): 96.5%

Data Source:

Call log data, shared with the state monthly by the call center

Description of Data:

The proportion of 988 and 414-LINK calls that are resolved over the phone, meaning they do not result in in-person intervention. In-person intervention includes first responder and mobile crisis response.

Data issues/caveats that affect outcome measures:

While it is often viewed as a positive for calls to be resolved over the phone, with the inception of CCBHCs we hope to expand mobile crisis response in Rhode Island, which may lead to an increase in calls resulting in in-person intervention (the inverse of calls resolved over the phone).

Priority #: 8

Priority Area: Children Experiencing Serious Emotional Disturbance

Priority Type: MHS

Population(s): SED, BHCS

Goal of the priority area:

Ensure children have access and are receiving behavioral healthcare services

Strategies to attain the goal:

Mobile Response Stabilization Services (MRSS) Program will be available to respond to outreach 24/7/365. Referrals will be accepted from 988-crisis hotline, schools, children's hospital, primary care providers, etc.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of unique children served by Mobile Response Stabilization Services (MRSS) Program for the entire state

Baseline measurement (Initial data collected prior to and during 2026): 2,051

First-year target/outcome measurement 2,092

(Progress to the end of 2026):

Second-year target/outcome measurement (Final to the end of 2027): 2.1%

Data Source:

Data is being collected through agency reporting to EOHHS

Description of Data:

Data will be submitted monthly by the agencies to EOHHS. EOHHS will incorporate into the MRSS Dashboard.

Data issues/caveats that affect outcome measures:

N/A

Indicator #: 2

Indicator: Percentage of Mobile Response Stabilization Services (MRSS) Program calls responded to within one hour

Baseline measurement (Initial data collected prior to and during 2026): 43%

First-year target/outcome measurement (Progress to the end of 2026): 45%

Second-year target/outcome measurement (Final to the end of 2027): 47%

Data Source:

Data is being collected through agency reporting to EOHHS

Description of Data:

Data will be submitted monthly by the agencies to EOHHS. EOHHS will incorporate into the MRSS Dashboard.

Data issues/caveats that affect outcome measures:

Sometimes the caller requests a specific time for response that may not be within one hour.

Priority #: 9

Priority Area: Person 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:

Screen incoming and current clients for tuberculosis. Refer any positive screens to RISE Clinic at Miriam Hospital

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Case rate of tuberculosis in RI

Baseline measurement (Initial data collected prior to and during 2026): 2.1 cases per 100,000

First-year target/outcome measurement (Progress to the end of 2026): 2.0

Second-year target/outcome measurement (Final to the end of 2027): 1.9

Data Source:

RIDOH TB Reporting based on calendar year.

Description of Data:

Cases per 100,000 of TB reported to RIDOH

Data issues/caveats that affect outcome measures:

There is a reporting lag between collection and dissemination. The baseline is from CY 2024. There may also be a ceiling effect due to low incidence in RI.

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Footnotes:

Planning Tables

Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	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), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds
1. Substance Use Disorder Prevention[a] and Treatment	$3,912,608.00		$0.00	$7,938,648.00	$18,456.28	$6,211,604.00	$0.00	
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$476,434.00					$200,000.00		
b. All Other	$3,436,174.00			$7,938,648.00	$18,456.28	$6,011,604.00		
2. Recovery Support Services[c]	$2,151,753.00			$7,904,374.00		$4,911,465.00		
3. Primary Prevention[d]	$5,657,876.00			$6,712,046.00		$4,800,383.00		
4. Early Intervention Services for HIV[e]	$0.00							
5. Tuberculosis	$0.00							
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)								
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care								
11. Crisis Services (5 percent Set-Aside)								
12. Other Capacity Building/Systems Development[f]	$3,062,851.00			$439,259.00		$480,224.00		
13. Administration[g]	$778,163.00			$2,663,651.00	$3,363,356.97	$200,000.00		
14. Total	**$19,475,859.00**		**$0.00**	**$33,596,626.00**	**$3,400,269.53**	**$22,815,280.00**	**$0.00**	

[a] Prevention other than primary prevention.

[b] Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

[c] This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

[d] Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

[e] 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.

[f] Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

[g] Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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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 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	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), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]		$670,678.00		$0.00				$40,853.00
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care		$3,685,959.00		$5,358,522.00				$347,253.00
11. Crisis Services (5 percent Set-Aside)[c]		$2,014,808.00						$20,427.00
12. Other Capacity Building/Systems Development								
13. Administration		$335,339.00		$745,928.00	$3,363,356.97			$0.00
14. Total		**$6,706,784.00**	**$0.00**	**$6,104,450.00**	**$3,363,356.97**	**$0.00**	**$0.00**	**$408,533.00**

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent 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: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

To complete the Aggregate Number Estimated in Need (Column A), please refer to the most recent edition of the **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 B), please refer to the most recent edition of the **Treatment Episode Data Set** (TEDS) data prepared and submitted to the Behavioral Health Services Information System (BHSIS).

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	649	134
Women with Dependent Children	29931	1448
Individuals with a co-occurring M/SUD	87010	10419
Persons who inject drugs	5513	3331
Persons experiencing homelessness	1810	1388

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is

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unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.
The 2023 NSDUH estimates that 25.37% (about 229,704) of Rhode Island residents aged 18 and older are in need of substance use treatment. 1A. Pregnant women - According to Kids Count there were 9,271 live births in 2023 - Healthy People 2030 estimates that that in 2017-18, 93% of pregnant females aged 15-44 abstained from illicit drug use in the past 30-days - 9271*(1-0.93) = 649 2A. Women with Dependent Children - Kids Count 2025 estimates that between 2019-2023, there were an average of 117,976 households with children under the age of 18 in Rhode Island - 117967*0.2537= 29,931 3A. Individuals with co-occurring M/SUD - According to the 2022-2023 NSDUH, 9.61% of adults aged 18 and older are estimated to have co-occurring AMI and SUD - The 2020 census estimates that there are 905,418 people aged 18 and older in Rhode Island - 905418*0.0961= 87,010 4A. Persons who inject drugs - The 2023 NSDUH estimates that 2.4% of adults aged 18 and older report lifetime heroin use - 229704*0.024=5,513 5A. Persons experiencing homelessness - The 2023 point in time estimate for persons experiencing homelessness according to the Rhode Island Coalition to End Homelessness is 1,810 persons - 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 Column B was calculated using treatment data for SUD based on anyone served in BHOLD system (source for Teds) in CY23. Persons experiencing homelessness includes homeless and shelter living arrangement.
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Footnotes:

Planning Tables

Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

Note: The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award
1 . Substance Use Disorder Prevention[a] and Treatment	$1,948,152.00
2 . Recovery Support Services[b]	$1,075,877.00
3 . Substance Use Primary Prevention[c]	$2,928,938.00
4 . Early Intervention Services for HIV[d]	$0.00
5 . Tuberculosis Services	$0.00
6 . Other Capacity Building/Systems Development[e]	$1,438,688.00
7 . Administration[f]	$389,034.00
8. Total	$7,780,689.00

[a]Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[b]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[c]This row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[d]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.

[e]Other Capacity Building/System Development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**. The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

[f]Per **45 CFR §96.135** Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Footnotes:

Planned expenditures are based on allocation tables created using reports of state accounting system.
We are also tracking using internal grant trackers created by Behavioral Healthcare Staff for State of RI.

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	
1b. Crisis Services for Adults	2014808.00
1c. CSC/ESMI program for Adults	
1d. Other outpatient/ambulatory services for Adults	
1e. *Other Direct Services for Adults	1969110.00
2. Subtotal of Services for Adults	3983918.00
3. Services for Children	
3a. EBPs for Children	
3b. Crisis Services for Children	
3c. CSC/ESMI program for Children	670678.00
3d. Other outpatient/ambulatory services for Children	
3e. *Other Direct Services for Children	
4. Subtotal of Services for Children	670678.00
5. Other Capacity Building/Systems Development[a]	1716849.00
6. Administrative Costs[b]	335339.00
7. *Any Other Cost	
8. Total MHBG Allocation[c]	**6706784.00**

Please provide brief explanation for services with an asterisk* below:

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

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Footnotes:

These allocations are in line with the rules and regulations that are outlined within this federal grant and are supported by Behavioral Healthcare in RI and our budget office.

The initiatives also line up with evidence based practices, our block grant application, and our division's strategic plan.

Planning Tables

Table 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award
1. Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
2. Education	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
3. Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
4. Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
	Universal	
	Selective	

5. Community-Based Processes	Indicated	
	Unspecified	
	Total	**$0**
6. Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
7. Section 1926 (Synar)-Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Budget		**$0**
Total Award [a]		**$7,780,689**
Planned Primary Prevention Percentage		**0.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Footnotes:

We are not required to complete Table 5a if we complete 5b.

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

Planning Tables

Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award
1. Universal Direct	$1,405,890
2. Universal Indirect	$556,498
3. Selective	$146,447
4. Indicated	$820,103
5. Column Total	**$2,928,938**
6. Total SUPTRS Award[a]	**$7,780,689**
7. Primary Prevention Percentage	**37.64%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Footnotes:

The projected expenditures are based on the approved plan. These costs do not include resource development as in previous years. This year's application breaks out resource development into its own category on table 4.

Planning Tables

Table 5c: SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award
Alcohol	☑
Tobacco/Nicotine-Containing Products	☑
Cannabis/Cannabinoids	☑
Prescription Medications	☑
Cocaine	☐
Heroin	☐
Inhalants	☐
Methamphetamine	☐
Fentanyl or Other Synthetic Opioids	☑
Other	☐
Priority Populations	
Students in College	☑
Military Families	☐
American Indian/Alaska Native	☐
African American	☑
Hispanic	☑
Persons Experiencing Homelessness	☐
Native Hawaiian/Pacific Islander	☐
Asian	☐
Rural	☐

Footnotes:

Planning Tables

Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Activity	FFY 2026		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	$0.00	$0.00	$299,120.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$299,120.00
2. Infrastructure Support	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$60,000.00	$140,000.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$60,000.00	$140,000.00	$0.00
4. Planning Council Activities	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$49,560.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$49,560.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$51,408.00

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a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$51,408.00
7. Training and Education	$302,366.00	$336,234.00	$200,000.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$302,366.00	$336,234.00	$200,000.00
8. Total	**$362,366.00**	**$525,794.00**	**$550,528.00**

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Footnotes:

The future expenditures are based on the approved plan. These totals of the 3 columns equal the total amount and tie into Table 4, row 6. "Other capacity building/systems development".

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 01/01/2026 MHBG Planning Period End Date: 01/01/2027

Activity	A. MHBG[1]	B. BSCA Funds[2]
1. Information Systems		
2. Infrastructure Support	$40,000.00	
3. Partnerships, Community Outreach, and Needs Assessment	$290,796.00	
4. Planning Council Activities		
5. Quality Assurance and Improvement		
6. Research and Evaluation		
7. Training and Education	$699,250.00	$172,723.40
8. Total	**$1,030,046.00**	**$172,723.40**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

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Footnotes:

These allocations tie into the amounts listed on Table 2 MH.

For Mental Health Block Grant funding - Table 2, Column, B, Row 10 has capacity building/systems development activities included in the amount (along with non 24 hour care). The amount matches what is listed in table 6.

For BSCA funds - Table 2, Columns H, Row 10 has capacity building/systems development activities included in the amount (along with non 24 hour care). The amount matches and ties into what is listed in table 6.

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **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 health 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: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

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 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 details on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

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

g) Persons with substance use disorders in the justice system

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

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

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

Rhode Island's System of Care focuses on the behavioral health continuum of care which is inclusive of both mental health and substance use services. The continuum focuses on transitioned age youth, adults, and older adults.

The continuum has levels of services ranging from community-based least restrictive care to the most restrictive levels of care of inpatient psychiatric hospitalization and detox.

Rhode Island's System of Care focuses on efforts to improve access to care for mental health, substance use, and co-occurring disorders, for children, youth, and adults. This includes and is not limited to the populations that are listed above (1a-1l). The continuum of care encompasses statewide integration of accessibility, delivery methods, and types of services to reach individuals based on their needs.

Rhode Island's Adult Behavioral Health continuum of care consists of programs and services from the following categories: 1.) Promotion and Prevention, 2.) Early Identification and Referral, 3.) Crisis Response and Stabilization Services, 4.) Home-and-Community-Based Treatment and Recovery Services (including Residential Programs), 5.) Short-Term Inpatient Psychiatric Care and Long-Term Institutional Care.

1.) Promotion and Prevention
Promotion is the process of informing the public about the importance of behavioral health and healthcare. Messaging helps people understand the importance of behavioral healthcare and specifically the importance of addressing the eight (8) dimensions of wellness, which include mental, physical, social, emotional, financial, spiritual, environmental, and vocational. BHDDH currently works with a statewide communications group seated in the Executive Office of Health and Human Services (EOHHS) that assists with promotional communications.

Prevention services in behavioral healthcare have three categories; universal which provides education to the whole population; selective which addresses the needs of individuals perceived to be at risk for behavioral health conditions due to their life situations; and indicated which is when a person has shown evidence of a having behavioral health condition. RI 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 more recently has invested in programming for adults. Seven (7) Regional Prevention Task Forces are responsible for overseeing the planning and delivery of substance use prevention activities.

2.) Early Identification and Referral
American Society of Addiction Medicine (ASAM) identifies one (1) level of screening and early identification referral, which is ASAM Level 0.5, Early Intervention. This level of care consists of assessment and education for people at risk of developing a substance use disorder.

Another example of identification is the Screening, Brief Intervention, and Referral to Treatment (SBIRT) at primary care practices and healthcare centers. A second example is student assistance counselors, who also conduct screenings in school settings and make referrals to treatment.

Lastly, BHDDH is working to implement the use of a standardized Global Assessment of Functioning (GloBHS) in other non-medical and healthcare settings.

3.) Crisis Response and Stabilization Services
Three (3) components of the Crisis Continuum are someone to talk to, someone to respond, and a safe place for help. 988 is a single point of access which is 24/7 for phone contacts with ten hours of capacity for texts and chats.

Rhode Island (RI) has mobile crisis responses for adults and children. Each CCBHC has emergency service departments which include a 24/7 staffed emergency line and 24/7 mobile crisis teams for their designated catchment/service area. CCBHC's mobile crisis teams respond to behavioral health and substance use crises for both adults and youth, utilizing a 2-person mobile crisis response for adults. The MRSS model for youth is discussed below in the Children's continuum of care section. All CCBHCs work with police and law enforcement in their catchment area to provide a mobile co-response, if indicated.

BH Link is a statewide 24/7 triage and receiving center for adults with capacity for 23-hour observation. In addition, there are three (3) 24-hour, short stay crisis stabilization units within the state that assist with behavioral health crises, hospital step-down and emergency room diversion.

4.) Home-and-Community-Based Treatment and Recovery Services (including Residential Treatment)

Community-Based Mental Health and Substance Use Treatment
Efforts to increase access to services for mental health and substance use services for adults and children has been made through the implementation of eight (8) CCBHCs throughout the state. Each CCHBC has availability for walk-ins and same day appointments. CCBHCs are required to meet standards in six (6) different program areas: 1.) Staffing, 2.) Availability and accessibility of services, 3.) Care Coordination, 4.) Scope of Services, 5.) Quality and other reporting, 6.) Organizational authority, governance, and accreditation.

In addition, the nine (9) federally required CCBHC core services will improve quality and access to services: 1.) Crisis Response, 2.) Screening, Evaluation, and Diagnosis, 3.) Person-Centered and Family-Centered Treatment Planning, 4.) Outpatient Mental Health and Substance Use Disorder Services, 5.) Primary Care Screening and Monitoring, 6.) Peer and Family Support, 7.) Psychiatric Rehabilitation, 8.) Targeted Case Management, 9.) Intensive-Community-Based Mental Health Care for Members of the Armed Forces and Veterans. CCBHCs may deliver these services directly, or through Designated Collaborating Organization (DCO) agreements.

Mental Health Treatment
The continuum the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) oversees as the state mental health authority (SMHA) for adults is described below.

BHDDH's mental health treatment continuum has levels of treatment that is consistent with an individual's level of need or acuity. The individuals served by BHDDH licensed providers consist of those with any mental health condition, serious mental illness (SMI), or serious and persistent mental illness (SPMI). Children or youth under the age of 18 who have mental illness may be diagnosed with serious emotional disturbance (SED). They are also served in our system of care as well as receiving services funded through DCYF.

The services available to adults include crisis stabilization, residential services, supportive housing services, partial hospital and intensive outpatient programs, assertive community treatment, and other community-based treatment programs. Hospitalizations and inpatient level of care are also accessed by some of these individuals. These hospitals are licensed by the Rhode Department of Health (RIDOH) and are approved for facility status designation by the Licensing Division of BHDDH.

Individuals with SMI and SPMI that require nursing home level of care are reviewed by staff of the Pre-admission Screening Residential Review (PASRR) program, for their behavioral health needs, prior to placement.

BHDDH licenses four (4) levels of 24/7 staffed Mental Health Psychiatric Rehabilitative Residences (MHPRRs) ranging from supportive apartments, congregate living MHPRRs, specialized MHPRRs for individuals with co-occurring mental health and substance use conditions, and the newest Enhanced MHPRR (E-MHPRR) that services individuals with high intense behavioral and medical needs. MHPRRs provide increased structure and supervision for individuals whose mental illness requires more intense services than Assertive Community Treatment.

Substance Use Treatment
The continuum BHDDH oversees as the single state substance authority (SSA) for all ages are described below.

Currently, three (3) levels of Outpatient services are identified by ASAM that are provided by BHDDH-licenses providers, as well as private practitioners that are not licensed by BHDDH. These ASAM levels are Level 1 Outpatient, Level 2 Intensive Outpatient/Partial Hospitalization, and Level 3 Residential. ASAM Level 4 Inpatient services are provided in only one (1) hospital setting licensed by RIDOH.

In addition, BHDDH licenses and works closely with our federal Drug Enforcement Administration (DEA) and SAMHSA partners to ensure compliance and to provide oversight via the State Opioid Treatment Authority (SOTA) position; designated by BHDDH to monitor all opioid treatment programs (OTPs).

Seventeen (17) separate OTP locations are throughout the state. The OTPs provide medications for opioid use disorders with medications such as methadone, buprenorphine, and naltrexone. Additionally, OTPs offer support services such as HIV/HEP C and TB screening, relapse prevention and counseling. Individuals may also access OTP health home services to address physical health and other social determinants of health. OTP programs throughout the state provide open access to services along with one (1) OTP provider who has two (2) mobile vans that work to engage individuals that need medication(s) for an opioid use disorder (MOUD). Additionally, a Buprenorphine Hotline is available that provides telehealth services for initiation of buprenorphine treatment 24/7.

Currently, the system has twelve (12) licensed Substance Use Disorder (SUD) Residential locations in the state. BHDDH-licensed providers offer three (3) ASAM levels of residential services for individuals with an alcohol, or a SUD. Those levels are 3.1, 3.5 and 3.7.

RI Behavioral Health Open Beds is a public information online website for healthcare providers, clients, and caregivers for transparency of bed availability in substance use detox and residential, inpatient psychiatric facilities, and recovery house settings. Open Beds includes information of vacancies for beds for children, adolescents, adults, and geriatric individuals.

Recovery Services
Recovery Community Centers (RCCs) are peer-operated centers that serve as local resource hubs for community-based recovery support. RCCs help individuals build recovery capital at the community level by providing mutual aid, support, resource navigation, advocacy, training, school activities, employment and education support, and other community-based services. BHDDH funds five (5) RCCs across the state.

RI was the first state to institute a certification for peer recovery specialists (PRS) that encompassed both mental health and substance use information. PRS are individuals with lived experience of a behavioral health condition. PRS work in a variety of settings that include but are not limited to, treatment team models, as crisis respondents, as individuals conducting outreach, and in recovery community centers. Agencies that wish to receive Medicaid reimbursements for services must demonstrate their compliance with peer certification standards and apply to the state to become certified.

Recovery Houses offer a substance free living environment for individual recovery from SUD. While recovery houses are not required to be licensed, RI requires that all referrals made to state-funded recovery houses must be certified residences that meet the national standards outlined by the National Alliance of Recovery Residence (NARR).

RI has ten (10) NARR certified Recovery House providers that support forty-two (42) NARR certified Recovery Houses across the state. 942-STOP is the phone line and number for individuals to contact for placement into state funded recovery houses.

5.) Short-Term Inpatient Psychiatric Care and Long-Term Institutional Care
RI has seven (7) short-term inpatient adult psychiatric care facilities. In addition, three (3) children and adolescent inpatient psychiatric units are located at three (3) different hospitals throughout the state.

Eleanor Slater Hospital (ESH) is the only long-term acute care hospital (LTACH) in our state. In addition, RI has a standalone forensic psychiatric hospital (RISPH) in our state.

Children's Behavioral Health

The Children's Behavioral Health continuum of care consists of the following program components: 1.) Prevention, 2.) Mobile Response and Stabilization Services (MRSS), 3.) Ensuring a Strong Service Array, 4.) Care Coordination.

1.) Prevention
Prevention is broadly defined for children and caregivers within the following types: 1.) Universal Physical, Behavioral, and Social Health Promotion, 2.) Universal Screening and Early Identification, 3.) Enhanced Prevention for At-Risk Populations, 4.) Tertiary Prevention.

The universal physical, behavioral, and social health promotion activities for prevention include health and wellness policy, mental health promotion, social emotional development, and protective factors.

The universal screening and early identification prevention activities include developmental screening, behavioral health screening, and social determinants of health screening.

Enhanced prevention for at-risk populations involves targeted outreach, engagement, and retention, along with additional resource provision, transition coordination, and severity escalation mitigation.

Tertiary prevention activities are defined to include prevention of onset of a more severe condition, and prevention of recurrence thru step-down care coordination.

2.) Mobile Response and Stabilization Services (MRSS)
The goal of MRSS is to have services that can intercede before urgent behavioral situations become unmanageable. MRSS is designed to reduce unnecessary emergency department (ED) visits, reduce placement disruptions/out-of-home placements, reduce overall system costs, reduce disparities, and increase juvenile justice diversion. RI's overarching goal is to create a more unified and cohesive system to assist and guide families where to get help and to ensure that their children receive the highest quality of care in a community-based setting.

3.) Ensuring a Strong Service Array
The goal is to develop and expand services and supports by ensuring investments in an adequate, responsive, and broad service array. Establishing outreach plans, alignment with pediatricians and family practice physicians, improvement of family clinical services, and integrated standardized tools; are activities that will ensure a strong service array.

Other activities include but are not limited to home-based services, such as, school and outpatient services, and residential services. DCYF has an array of home-based services that include mental health services, family stabilization and prevention services, parent skill building services, kinship, foster care and adoption services, family visitation, and aftercare and transitional services.

4.) Care Coordination

The goal is to expand access to intensive care coordination/wraparound facilitation to promote long-term wellbeing for children and families who are confronting serious behavioral health challenges. Furthermore, care coordination also includes children and families who need multi-systematic help while also reducing inequities in access to high quality behavioral health care.

High fidelity wraparound is a care coordination model that is a best practice for our systems of care. Expanding high fidelity wraparound facilitation will support a family to direct their own care and ultimately sustain connections and promote wellbeing without long-term assistance. Currently, high fidelity wraparound facilitation is provided through five (5) regional DCYF-contracted Family Care Community Partnerships (FCCPs).

DCYF also offers a range of intensive, in-home evidence-based or evidence informed services. Many of these services, such as Multi -Systemic Therapy, Family Centered Treatment, Trauma Systems Therapy, Home-Based Therapeutic Services (HBTS), and other services, include a care coordination component that is delivered as part of the clinical in-home treatment.

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.

BHDDH has been involved in advancing parity enforcement and increasing awareness of parity protection in collaboration with state partners of the Office of the Health Insurance Commissioner (OHIC) and Medicaid.

Summary of efforts:
• OHIC monitors compliance with the federal mental health parity act and plays a significant role in managing Medicaid.
• OHIC has worked with a diverse group representing consumers, businesses, and healthcare providers to ensure parity of health care providers.
• BHDDH supports the RI Parity Initiative through the Rhode Island Mental Health Association, which is another public awareness and education effort aimed at empowering individuals to understand and assert their right to health insurance coverage for mental health and substance use disorder treatment and services.
• Through Rhode Island Parent Information Network (RIPIN), OHIC maintains a consumer assistance helpline called RIREACH (Rhode Island Insurance Resource, Education, and Consumer Helpline) to provide support, education and advocacy to Rhode Islanders facing health care barriers. A consumer complaint can also be filed on OHIC's website.

3. 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.

CCBHCs have two (2) levels of team-based Assertive Community Treatment (ACT) that provide services to adults 18+ and one team-based ACT program for youth ages 15-26. All these teams provide screening, support, and integrated care for co-occurring disorders.

ACT is a multidisciplinary team that provides comprehensive treatment, support, and rehabilitation services. The goals of ACT services are to help individuals become independent and integrate into the community as they experience recovery. Individuals eligible for this level are reviewed using a Daily Living Activities (DLA) instrument and are to have a score of four (4) or less to be eligible for services.

Below is a brief description of the ACT levels of care:
• ACT-I is a high intensity level of service that is needed when an individual's care requires a multidisciplinary team approach to providing comprehensive treatment, support, and rehabilitation services.
• ACT-II is a lower intensity level of service that is needed when an individual may not require the ACT-I level of support and would benefit from a team-based approach.
• ACT-YA (Young Adult) level of service is needed for individuals ages 15-26 who are having impaired functioning in the community, that require continuous high service needs, that have not been met by the traditional outpatient setting.

In addition, as stated in the CCBHC Standards, the core services for these programs include integrated treatment for physical health and behavioral health, counseling, rehabilitative, employment and supportive services such as: crisis intervention; psychiatric medication; psychosocial rehab; mental health and/or SUD evidenced based treatment; case management services; care coordination; health home services; Individual and Placement Services (IPS) programming, and social skills and interpersonal relationship training, as needed related to client intensity.

The team staffing requirements covers multiple disciplines consistent with the evidence-based practice for ACT to provide wraparound services to individuals with co-occurring mental health and substance use disorders. All levels of ACT teams require a specific number of contacts per month, and ACT-I and ACT-YA have active operation hours during weekends and holidays. (More detail can be found under 6. Statutory Criterion).

a. Please describe how this system differs for youth and adults.

ACT-YA differs from ACT teams for adults in reference to the team census size being smaller. A competitive RFP process will utilize MHBG funds to implement the evidenced-based Coordinated Specialty Care model at two (2) selected CCBHCs. These two (2) programs will be tailored to meet the first episode psychosis (FEP) set aside of the MHBG. (More detail can be

found under 2. ESMI).

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

Yes. IT-COD is provided at one (1) of our CCBHC agencies. It is an evidence-based approach designed to address co-occurring mental health and substance use disorders by integrating both modalities of treatment. It is an assertive outpatient program that assists individuals with recovery. The program currently has a census of 100 individuals and has served 155 individuals since January 2025.

c. How many IT-COD teams do you have? Please explain.

Currently, one IT-COD team is located at a CCBHC.

d. Do you monitor fidelity for IT-COD? Please explain.

The CCBHC has an agreement with Case Western University, Ohio for fidelity monitoring of this model.

e. Do you have a statewide COD coordinator? ○ Yes ◉ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. 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

d) How the state provides integrated treatment for individuals with co-occurring disorders

A.) The state supports access to behavioral health care facilitated through primary care providers (PCPs) by having Care Coordination Agreements between PCPs and CCBHCs. This strengthens coordination of care and improves the relationship between both providers.

Additionally, access to behavioral health care is facilitated through PCPs by utilizing assessment tools to screen and evaluate clients for mental health and substance use disorders. This assists with establishing referrals and providing linkages to services. These assessment tools aid in early detection and monitoring. Three (3) examples are Patient Health Questionnaire (PHQ), Generalized Anxiety Disorder (GAD), and Alcohol Use Disorder Identification Test (AUDIT).

Access to behavioral health care is also facilitated through networking and outreach by OTP Liaisons to PCPs. Outreach and education are made at locations such as PCPs, EDs, SUD programs, pre-release, diversion, courts, and housing agencies. Medication assisted treatment referrals are the results of these efforts.

B.) The state supports efforts to improve behavioral health care provided by PCPs.

PCP offices may have certified or licensed staff to provide behavioral health services. Some examples of these services include counseling, case management, care coordination and recovery supports,

C.) The state supports efforts to integrate primary care into behavioral health settings. CCBHCs are required to provide primary care screening and monitoring. This involves inquiring if individuals have a PCP, assisting individuals who do not have a PCP to acquire one, and establishing policies and procedures that promote and describe the coordination of care with PCPs.

CCBHCs are to have Care Coordination Agreements in place with PCPs. Each CCBHC is to inform the individual's PCP of any changes in their comprehensive evaluation, including updates to a functional assessment.

Lastly, CCBHCs are required to have trainings for SBIRT and Policy and Procedures for Integration with Primary Care.

D.) The state provides integrated treatment for individuals with co-occurring disorders through a current co-location agreement between one (1) CCBHC and two (2) community health centers in their designated service area. This co-located integrated treatment approach provides the framework for wellness and recovery.

5. 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 (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

Care coordination is funded through a variety of funding sources.
1.) CCBHCs are Medicaid funded through the Prospective Payment System 2 (PPS-2) rate.
2.) RCCs are funded through braided funding from SUPTRS BG, SOR, and Opioid Settlement.
3.) DCYF's children and youth care coordination is funded through Medicaid, state general revenue, and MHBG for FY2026.

CCBHCs provide care coordination to adults with SMI, SUD, and I/DD along with children and youth with SED, SMI, and I/DD (5a-5e). CCBHCs are required to have Care Coordination Agreements within their designated service area. Some examples of these agreements are primary care providers, hospitals, urgent cares, courts, law enforcement, local emergency management transport (EMT), OTPs, and providers specialized in support and services for adults and children with I/DD. CCBHCs may also have Care Coordination Agreements with an agency with SSI/SSDI Outreach, Access, and Recovery (SOAR)-trained individuals who can support SSI and SSDI applications, unless they have an existing person trained at the agency.

Each CCBHC has a Care Coordination Agreement to work with the Continuum of Care Collaborative to take referrals for those needing Home Stabilization services and outreach in their designated service area. CCBHC also have ACT teams and general outpatient programs staff such as, case managers and vocational specialists that assist with care coordination regarding connection to providers, education, employment, and housing.

ACT provides care coordination to adults with SMI, SUD, and I/DD (5a-5c). ACT has two (2) adult levels of care based on seriousness and complexity of behavioral health needs. The high intensity level of ACT (ACT-I) provides increased service delivery regarding required contacts and on-call operation availability. As described previously, ACT II is a lower level of intensity that provides a required number of contacts.

RCCs provide care coordination to adults with SUD (5b). RCCs help build internal and external resources at the community level by providing mutual aid support, resource navigation, employment and education support, and other community-based services to adults with substance use disorders. Currently, five (5) RCCs are associated with three (3) CCBHCs. The RCCs provide additional peer supports and resources for those in recovery.

DCYF provides care coordination to children and youth with SED, SUD, and/or I/DD (5d-5e). DCYF has several in-home evidence-based or evidence informed programs through DCYF that provide care coordination. Some examples were noted in the Children's Behavioral Health continuum of care in question one (1) of this document. Care coordination for children and youth is provided through a variety of means depending on a child and family's needs, strengths, preferences and choice, and prior treatment history. Care coordination services consist of transportation assistance, advocacy and support within systems, resource development, intensive short-term care coordination, linkage to services, and attendance at provider meetings.

6. 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.

CCBHCs have two (2) levels of team-based Assertive Community Treatment (ACT) that provide services to adults 18+ and one team-based ACT program for youth ages 15-26. All these teams provide screening, support, and integrated care for co-occurring disorders.

ACT is a multidisciplinary team that provides comprehensive treatment, support, and rehabilitation services. The goals of ACT services are to help individuals become independent and integrate into the community as they experience recovery. Individuals eligible for this level are reviewed using a Daily Living Activities (DLA) instrument and are to have a score of four (4) or less to be eligible for services.

Below is a brief description of the ACT levels of care:
• ACT-I is a high intensity level of service that is needed when an individual's care requires a multidisciplinary team approach to providing comprehensive treatment, support, and rehabilitation services.
• ACT-II is a lower intensity level of service that is needed when an individual may not require the ACT-I level of support and would benefit from a team-based approach.
• ACT-YA (Young Adult) level of service is needed for individuals ages 15-26 who are having impaired functioning in the community, that require continuous high service needs, that have not been met by the traditional outpatient setting.

In addition, as stated in the CCBHC Standards, the core services for these programs include integrated treatment for physical health and behavioral health, counseling, rehabilitative, employment and supportive services such as: crisis intervention; psychiatric medication; psychosocial rehab; mental health and/or SUD evidenced based treatment; case management services; care coordination; health home services; Individual and Placement Services (IPS) programming, and social skills and interpersonal relationship training, as needed related to client intensity.

The team staffing requirements covers multiple disciplines consistent with the evidence-based practice for ACT to provide wraparound services to individuals with co-occurring mental health and substance use disorders. All levels of ACT teams require a specific number of contacts per month and ACT-I and ACT-YA have active operation hours during weekends and holidays. (More

detail can be found under 6. Statutory Criterion).

ACT-YA differs from ACT teams for adults in reference to the team census size being smaller. A competitive RFP process will utilize MHBG funds to implement the evidenced-based Coordinated Specialty Care model at two (2) selected CCBHCs. These two (2) programs will be tailored to meet the first episode psychosis (FEP) set aside of the MHBG. (More detail can be found under 2. ESMI).

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

CCBHCs provide integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD) The program placement and level of care is based on the client's needs. Co-occurring mental health and I/DD individuals are eligible for the complete array of CCBHC programs and services.

8. Please indicate areas of **technical assistance needs** related to this section.

N/A

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for 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 individuals 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 as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: 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 SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The 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-5TR (APA, 2022). 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 the 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 experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The 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.

States 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 experiencing 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.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
Coordinated Specialty Care (CSC) Enhancement for First Episode Psychosis (FEP)	2.00
	0.00
	0.00
	0.00

	0.00
	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
550,000.00	550,000.00

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

CCBHC ACT-YA services are currently billed through Medicaid based on the Prospective Payment System (PPS) rate.

The CSC for FEP structure of services will be provided through team FTEs that are to be funded through the MHBG. The Coordinated Specialty Care (CSC) programming for FEP is not reimbursable through Medicaid and not part of the CCBHC cost reports and will not apply to the PPS rate.

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

ACT-YA is the level of service needed for individuals who are 15-26 years old with ESMI that impairs functioning in the community, have continuous high service needs, who lack engagement in, and whose needs have not been met in traditional outpatient services. ACT-YA is a program that will use assertive and intentional engagement strategies to work with individuals who may have needs that are unable to be met within general outpatient services.

The CSC programs for FEP will improve the ACT-YA service provision by the structure focusing on individuals who are 15-26 years old with FEP. Individuals can benefit from time limited evidence-based practices to improve the overall trajectory of illness presentation and provide specialized family supports.

5. Does the state monitor fidelity of the chosen EBP(s)? (●) Yes ( ) No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

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

ACT-YA provides eight or more contacts per month, and at least four of those contacts must be provided in person with the individual being served. ACT-YA operations require ten hours of team active operation during weekdays and four hours per day on weekends and holidays along with an on-call worker from the ACT team 24/7 for client emergencies to triage with crisis workers. This program is composed of various mental health professionals, licensed and non-licensed, to include a team lead, who is required to be a licensed professional, registered nurse(s), certified/licensed clinician(s), certified/license substance use disorder specialist, vocational specialist, and CPST/case manager(s). Each team allows for additional flex positions depending on the team needs.

The CSC programs for FEP could include FTE combinations of 100% or alternative staffing plans with varied percentages of FTEs depending on LOE to the service provision. Positions would be set to deliver the core CSC components.

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

ACT-YA will continue to operate and remain within compliance of the CCBHC Certification Standards.

The CSC programs for FEP will hire for the team service positions, complete specialized trainings, provide CSC treatment service delivery for FEP, and conduct outreach and engagement.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

- Bipolar disorders
- Post-traumatic stress disorder
- Borderline personality disorder
- Major depressive disorder
- Obsessive compulsive disorder
- Conduct disorder (ODD only 18 and younger),
- Psychotic disorder/Affective disorder with psychosis
- Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence.

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

The estimated annual incidence of individuals experiencing first-episode psychosis (FEP) in Rhode Island was 97 per 100,000 in

2024.

Incidence was determined using Rhode Island Behavioral Health On-Line Database 2.0 (BHOLD) and Census Bureau data. From BHOLD, 1062 unique individuals were identified as experiencing FEP if they were newly admitted with a qualifying primary diagnosis of psychotic disorders or affective disorders with psychotic features during 2024. From the Census Bureau, Rhode Island's total estimated population in 2024 was 1,095,371.

A qualifying primary diagnosis was determined using International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes for psychotic disorders i.e. schizophrenia, schizotypal, and delusional disorders [F20-F29] and affective disorders with psychotic features [F30.2, F31.2, F31.5, F32.3, F33.3].

Annual incidence was calculated by dividing the 1062 unique individuals identified as experiencing FEP by Rhode Island's estimated total population of 1,095,371, the result was then multiplied by 100,000 for ease of comparison.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

The CSC FEP programs will engage individuals experiencing FEP who may not initially engage in enrolled team treatment services. The CSC teams will provide FEP psychoeducation to families outreached.

The CSC teams will outreach community secondary education systems and post-secondary education systems to cultivate referrals for ESMI and FEP.

The CSC teams will coordinate services with early intervention community providers (pediatrics, hospitals, clinics), other behavioral health providers, NAMI local chapter, Mental Health Advocacy RI's Young Adult Advocate and social service programs to cultivate referrals for ESMI/ FEP.

12. Please indicate area of technical assistance needs related to this section.

N/A

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process 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. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

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 people with SMI and their caregivers in making health care decisions, and enhances communication.

The Department of Behavioral Healthcare, Developmental Disabilities, and Hospital have rules and regulations for Behavioral Healthcare Organizations (BHOs). The purpose of the regulations is to adopt standards for licensure and operation of facilities and program providing behavioral health services for adults and/or substance use disorder services for children and adults (212-RICR-10-10-01). The person-centered plan is 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.

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

Based on the biopsychosocial assessment, a goal-oriented, recovery-focused individualized treatment plan shall be developed and implemented with each person served. A new treatment plan shall be developed at least once every twelve (12) months. The treatment plan is completed at multiple levels of care: residential programs, partial hospitalization programs, intensive outpatient programs, opioid treatment programs, and general outpatient programs.

The treatment plan shall contain the following elements:
• The unique needs, expectations, and characteristics of the person served into an appropriate, personalized, and comprehensive plan
• Written and coded multiaxial DSM diagnoses and/or ICD codes demonstrating a clear connection between the diagnoses, the data and integrated summary documented in the assessment, and the goals and interventions identified on the treatment plan
• Observable and measurable long and short-term goals formulated by the persons served
• Interventions, services, tasks of supports needed to attain goals
• Validation shall be recovered no later than two (2) weeks after completion of the plan
• The treatment plans of individuals receiving services in a CMHC, residential, or assertive community treatment program require the signature of a psychiatrist

Goals and interventions indicated in the treatment plans shall be reassessed, updated, and modified every six (6) months as necessary, and at each of the following events: 1.) at the time of the individual's admission to a specific service or program; 2.) upon changes in the individual's conditions or level of care; 3.) at the time of an internal transfer between programs; 4.) when an intervention is completed or a goal attained; 5.) when an intervention is not helping the individual attain the desired outcome; 6.) upon the individual's frequent use of crisis intervention services; 7.) if any individual refuses services or makes himself/herself unavailable for services; 8.) at the request of the persons served.

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 **A Practical Guide to Psychiatric Advance Directives**)?

Rhode Island does not currently have a status for Psychiatric Advance Directives.

6. Please indicate areas of technical assistance needs related to this section.

N/A

Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's program integrity efforts are to promote the proper expenditure of Block Grant funds, improve Block Grant program compliance nationally, and demonstrate the effective use of Block Grant funds

While some states have indicated an interest in using Block Grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 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)**, there are periodic 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. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. 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 private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based 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 behavioral health 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 mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

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

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

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

There is a contract monitor assigned to each contract. This role involves reviewing invoices and back-up documentation provided monthly to ensure that it aligns with the approved Budget and Budget Narrative based on the SAMHSA guidelines and the Uniform Grant Guidance. If a provider requests a change to their original budget, a budget change form needs to be submitted for prior approval. There is a program liaison assigned to each contract. This role involves meeting with the provider monthly to review the scope of work regarding tasks and deliverables. This is a time to focus on strengths of the program along with addressing issues and concerns as they arise. There are internal unit meetings to review the contracts in a larger setting to discuss fiscal and programming compliance and planning.

4. Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions 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 use 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 serve 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):

- **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)** ☑ Rural communities

i) ☐ Other (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) ☐ Other (please list)

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ◉ Yes ○ No

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

BHDDH has a prevention structure that includes the Regional Prevention Task Force (RPTF) coalitions and the Student Assistance program. RPTF coalitions are funded using a population-based formula by municipality within the region. Student Assistance program funding determinations are made based on a school's readiness and ability to provide a funding match.

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

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

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

Capacity Building

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

a) If yes, please describe.

The Rhode Island Certification Board has several certifications pertaining to the primary prevention workforce. The certifications are: Associate Prevention Specialist (APS), Certified Prevention Specialist (CPS), Advanced Prevention Specialist (ACPS), and Student Assistance Counselor (SAC). Each certification has requirements involving formal education, work experience, education/training, and examination along with re-certification process to ensure continued education/training.

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.

The Rhode Island Prevention Resource Center provides training, technical assistance, and capacity-building resources to substance use prevention providers and their community partners. C4 Innovations has developed and implemented peer recovery training.

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.

The proposal involves organizational background and capacity regarding mission, employees, physical and financial infrastructure, and capacity for reporting and invoicing. The proposal would include a work plan demonstrating how the provider will achieve the requirements in the scope of work through tasks and deliverables. The proposal would also include data collection and an evaluation plan.

BHDDH is rebidding the Regional Prevention Taskforces for a 10/1/2026 start per Department of Administration (DOA). BHDDH will be rebidding Rhode Island Student Assistance Services (RISAS) soon thereafter in alignment with the SOR IV's

end date (up to 9/30/2028 pending 1 year no-cost extension).

Narratve Question

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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 WebBGAS

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

- [x] Yes
- [ ] No
- [ ] Not applicable (no prevention strategic plan)

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)** [ ] 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

- **a)** Does the composition of the Advisory Council represent the demographics of the State? (●) 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 provides guidance to the Prevention Advisory Committee of the RI Governor's Council on Behavioral Health regarding the use of evidence-based practices for the delivery of services. The workgroup membership consists of a variety of behavioral health disciplines and included experts in behavioral health research, epidemiology and evaluation as well as behavioral health promotion and prevention providers. The focus of the workgroup is to develop guidelines for whether a given practice, policy, or program meets existing standard for evidence-based practices in behavioral healthcare and identify a process by which such can be designated as an evidence-based practice in RI. The workgroup developed an evidence-based practice application.

Narratve Question

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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 of our Rhode Island local and state 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 medicine, and cannabis 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 adult use of cannabis in 2023. RPTF coalitions are working with the cannabis dispensaries to ensure that identification checks are being performed. Information on the harmful effects of cannabis are distributed across the state through the regional prevention task forces. Underage drinking continues to be a high level 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 for Drugs by institutionalizing the curriculum through the health teachers. Newer evidence-based programs more recently implemented include Strengthening Families, Incredible Years, Sidelined, Mental Health First Aid, Media Detective, Media Ready, Positive Action, Smart Moves, Catch My Breath, Keepin it Real, Project Alert, Above the Influence, Family Matters, and Third Millenium.

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 76 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 (Schools Using Coordinated Community Efforts to Strengthen Students), an evidence-based program, in seventy-six Rhode Island middle and high schools. Over 52,000 students are served annually, 6,121 students received at least one topic of the Prevention Education Series curricula, and 6,288 were assessed for substance use. Project Success utilizes a combination 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. 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 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
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.

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) Yes (if so, please describe)

BHDDH ensures that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means based on these services not being covered under Medicaid or commercial insurance. Primary prevention is not considered a billable service under Medicaid or commercial insurance therefore the funding for these services relies on grant funding. BHDDH uses a contractual process that includes a primary prevention specific scope of work. The vendor provides a proposal detailing the initiatives they plan to implement and timeline. The vendor also provides a detailed budget and budget narrative. These are reviewed and approved by BHDDH staff prior to starting the primary prevention work.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions 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 use 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 serve 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 WebBGAS

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

- **a)** ☑ Establishes methods for monitoring progress towards outcomes, such as prioritized benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☑ Includes National Outcome Measurement (NOMs) requirements
- **d)** ☑ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☑ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please describe):
- **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)** ☑ Numbers served
- **b)** ☑ Implementation fidelity
- **c)** ☑ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

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

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy alcohol use
- **c)** ☑ Binge alcohol 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):

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

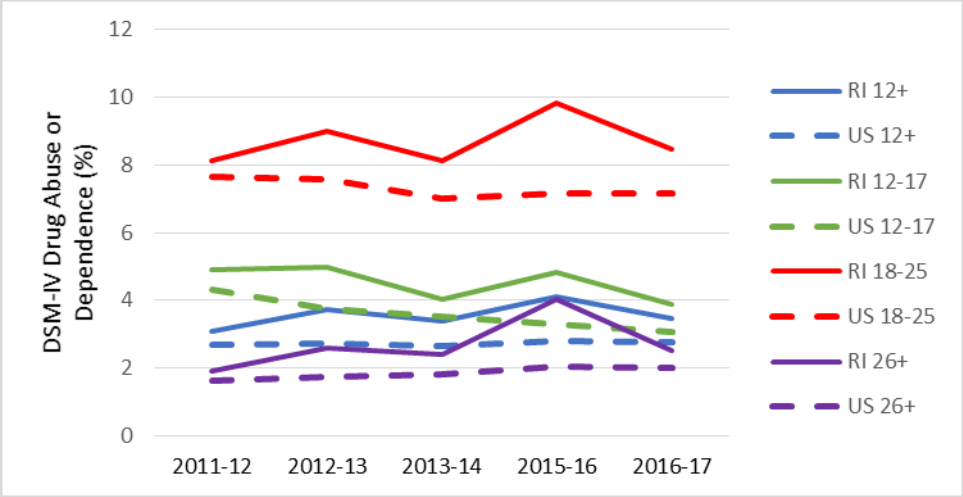
OBJECTIVE: The BHDDH 2019-2024 Strategic Plan contains the following objective related to overdose prevention: By December 2022, 100% of RI communities will sustain at least one activity promoting safer disposal practice previously funded by discretionary grants (Count It, Lock It, Drop media campaign: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

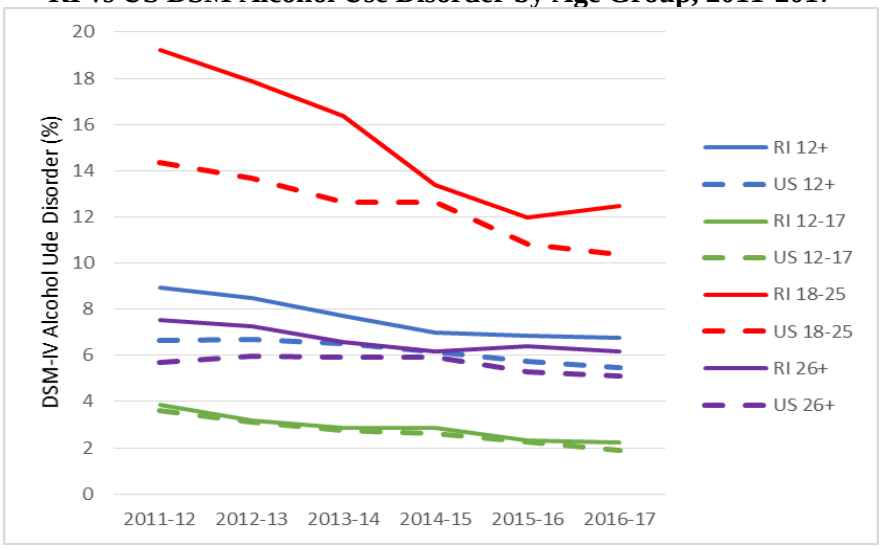
While diagnosis of substance use disorder as defined by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) diagnoses of substance use disorder are potentially changeable with primary prevention strategies, it will take considerably longer than the time frame covered in this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

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



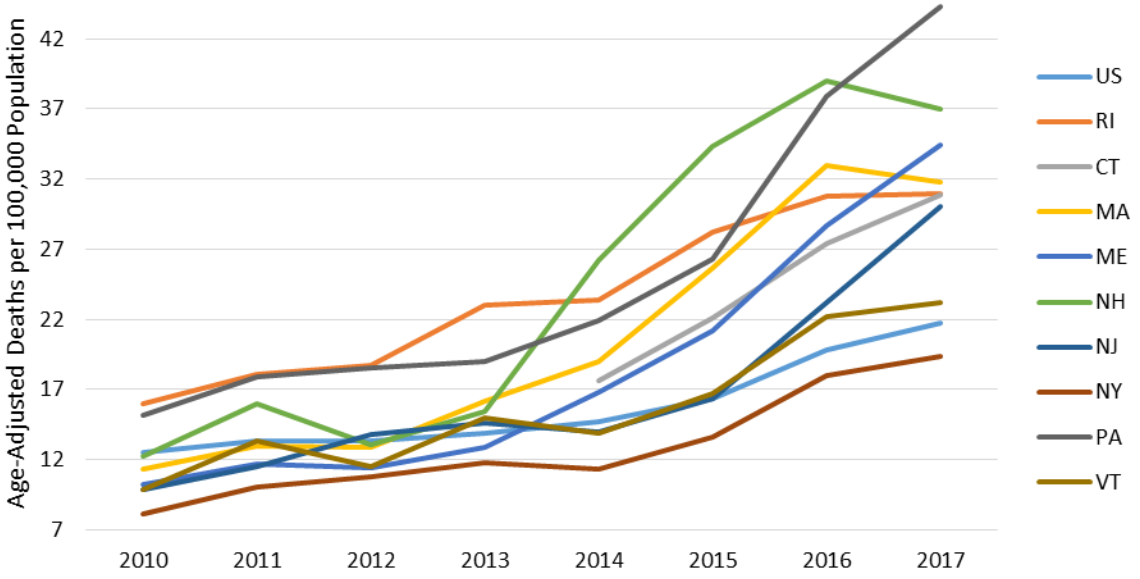
Source: National Survey on Drug Use and Health (NSDUH). **Note:** No data available for 2014-2015.

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



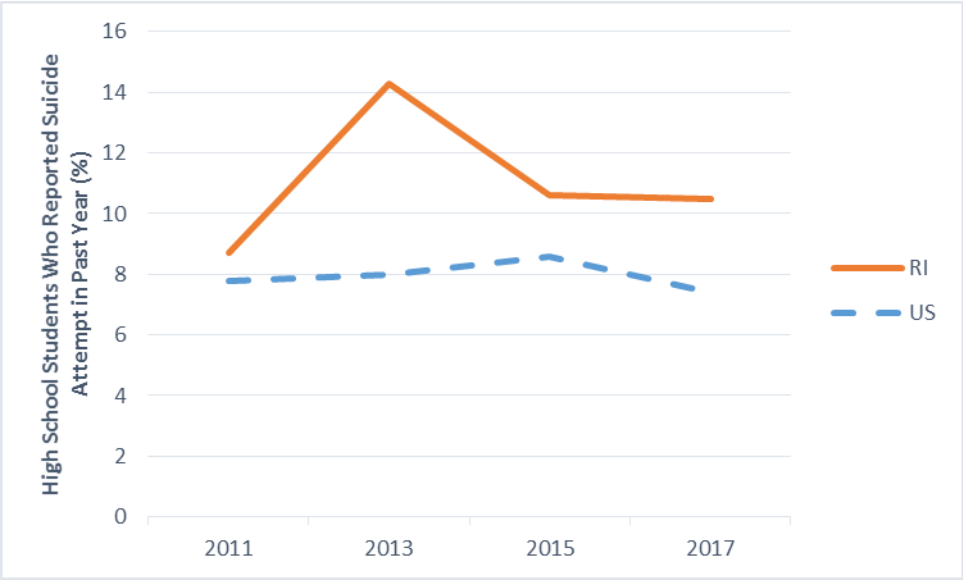
Source: National Survey on Drug Use and Health (NSDUH). ***Note:*** *Indicator name changed from Alcohol Abuse or Dependence to Alcohol Use Disorder in 2014-15.*

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.

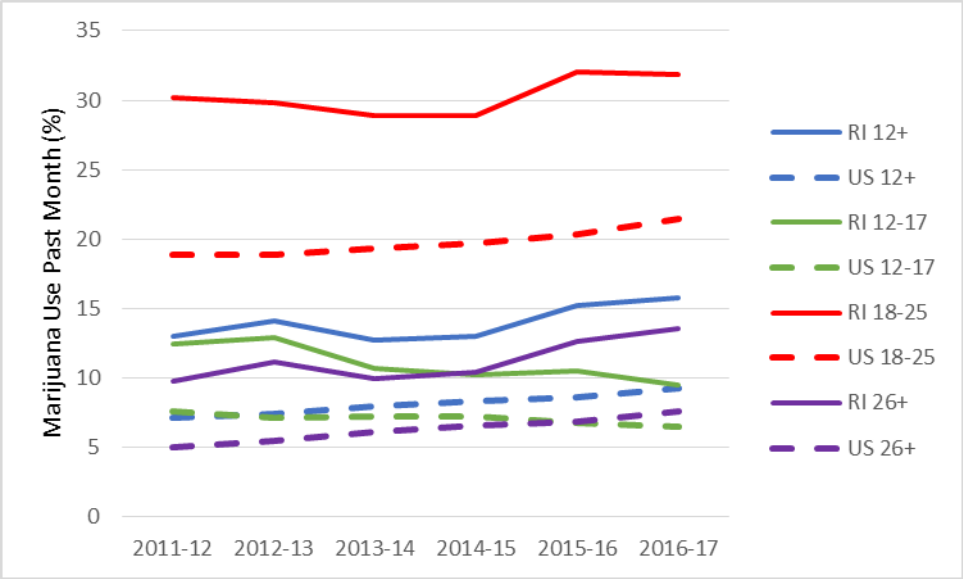
[1] Please note that the 2013 percentages reported in the chart above are believed to be an anomaly based on the RI Department of Health's review of other data for the same time frame

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

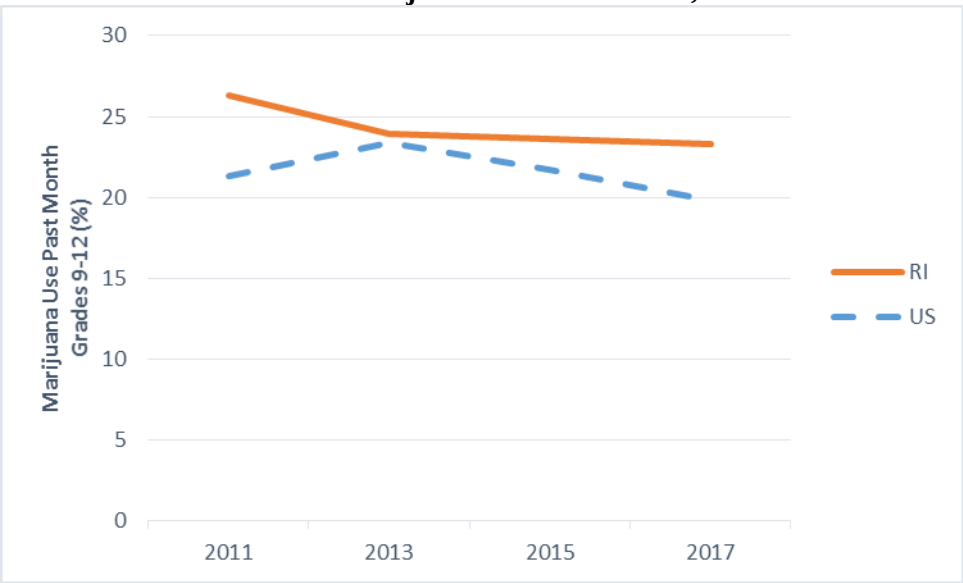


Source: National Survey on Drug Use and Health (NSDUH)

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



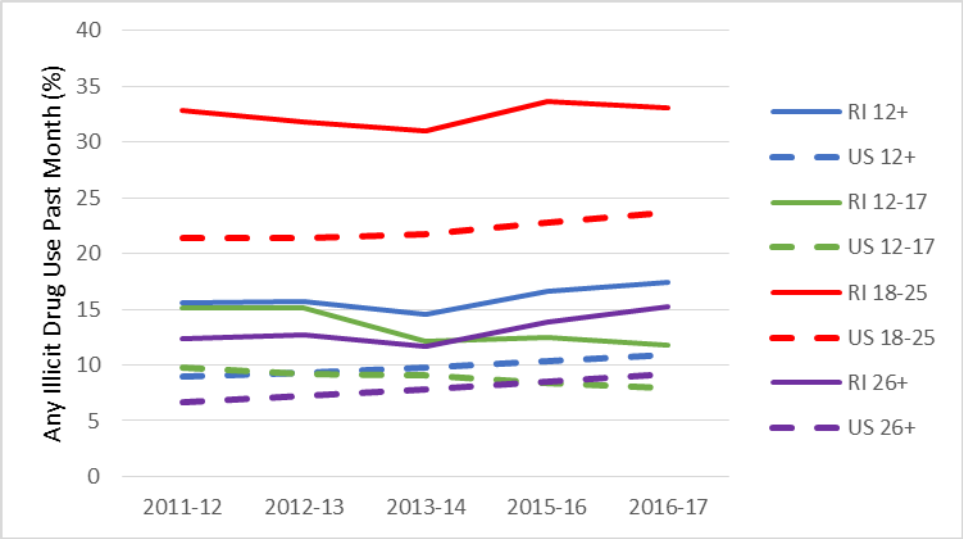
Source: Youth Risk Behavior Survey, Centers for Disease Control

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)

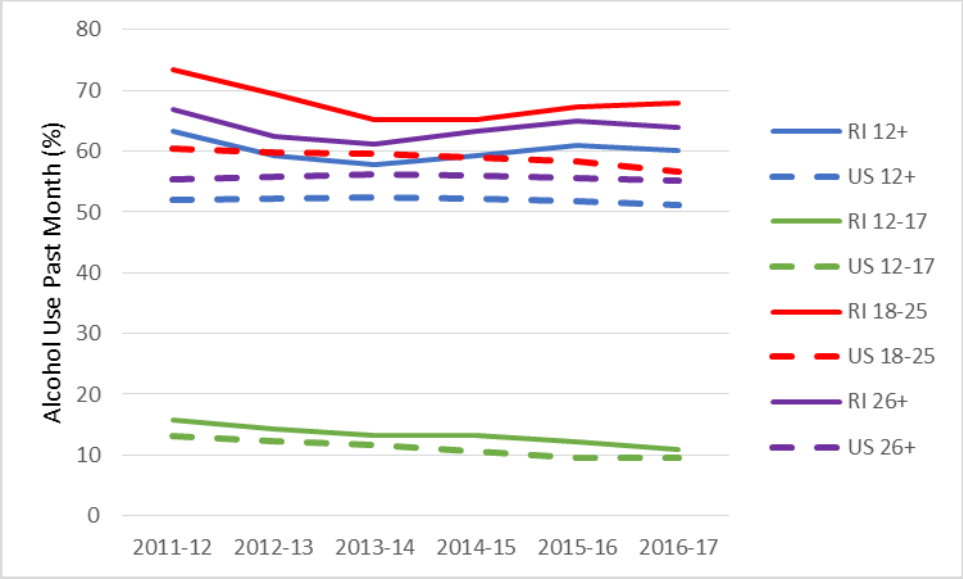
Underage Drinking and Past 30-Day Use Among Young Adults 18-25

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.

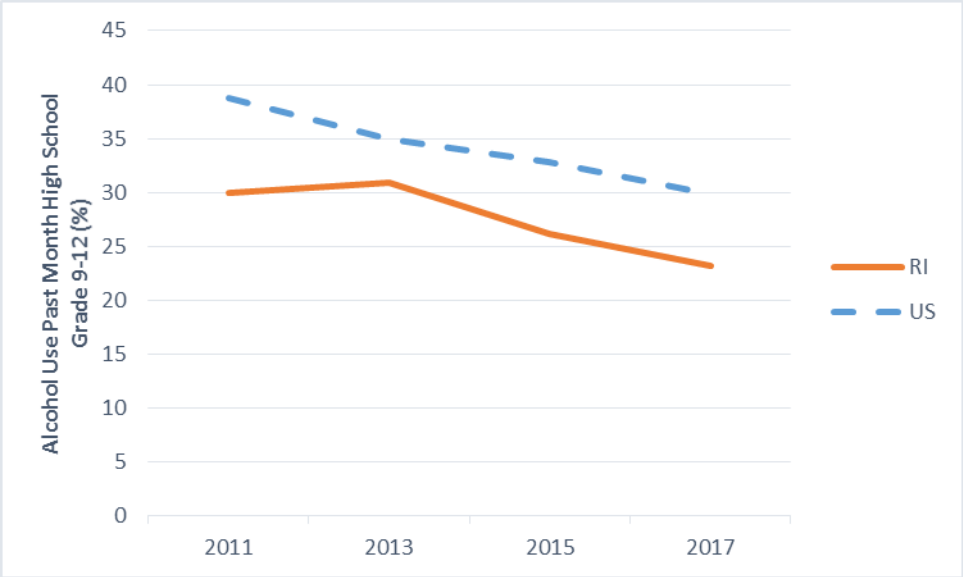
Alcohol Use Past Month by Age Group, 2011-2017



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

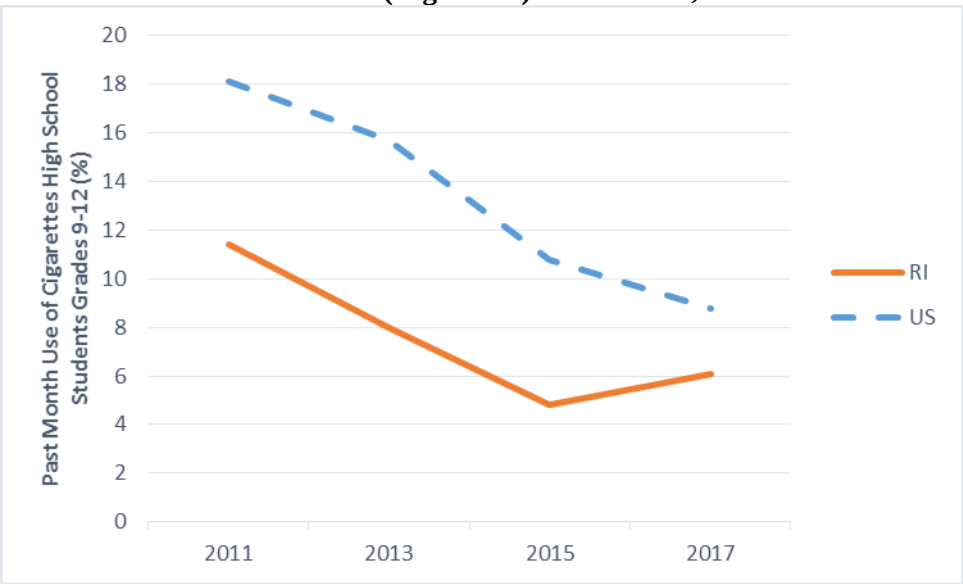
Youth Tobacco Use

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.

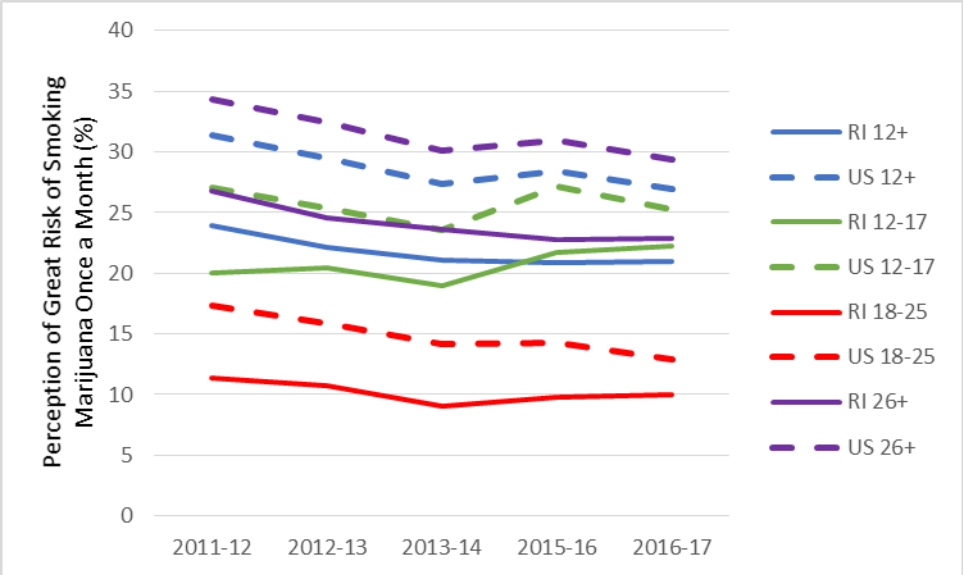
BHDDH provides funds through the Substance Abuse Prevention and Treatment Block Grant to RI communities to implement strategies to address these risk and protective factors. In addition, twenty Rhode Island communities are currently receiving funding through the Partnerships for Success II (PFS II) grant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

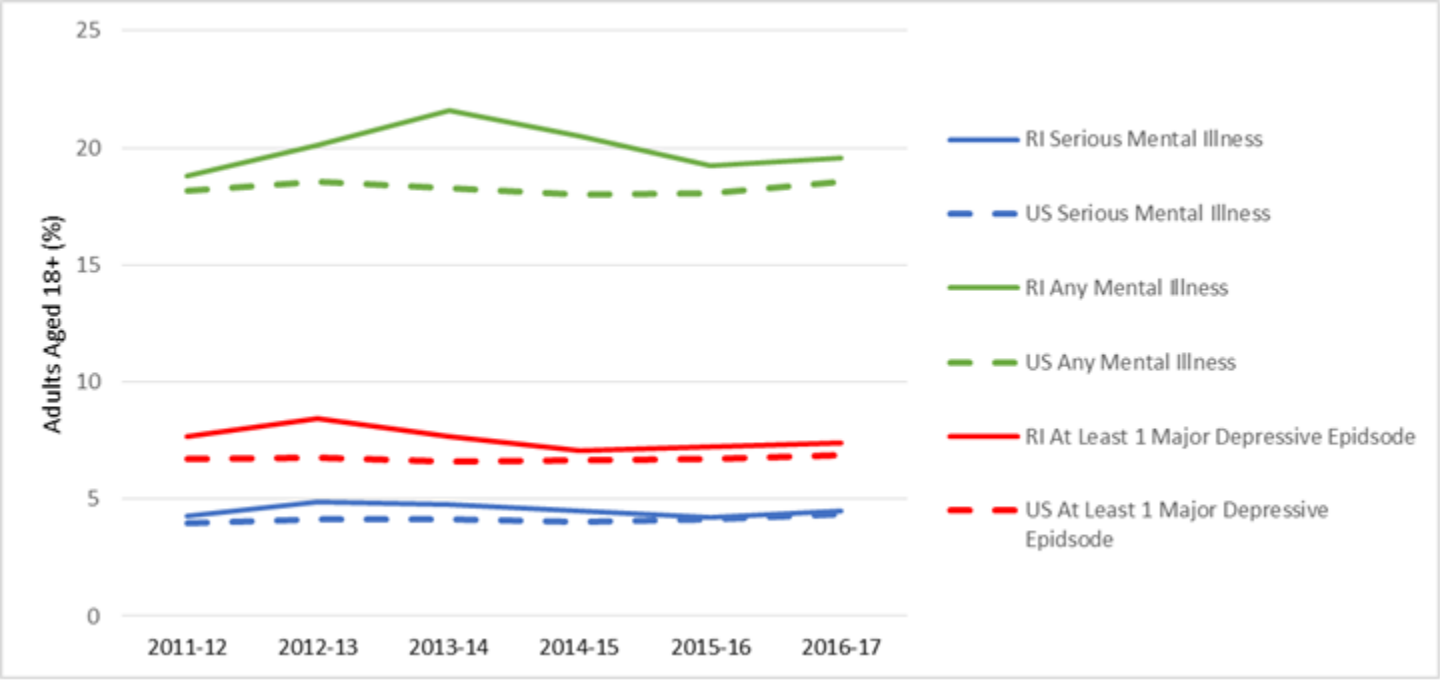
b. Access and Availability of Substances with Age Based or Other Conditional Use Restrictions

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.

Environmental Factors and Plan

6. 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-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Emergency Services, mobile crisis, and mobile response and stabilization services (MRSS) are provided 24/7 to adults and children. Requirements include 24-hours staffed hotline, 24-hours mobile crisis teams, 2-person mobile crisis response, and Qualified Mental Health Professionals (QMHPs) to provide clinic-based and mobile crisis intervention services.

Assertive Community Treatment I (High Intensity) level of service is needed when an individual's care requires a multidisciplinary team approach to providing comprehensive treatment, support, and rehabilitation services. ACT-I (High Intensity) teams provide eight or more contacts per month, with a minimum of four of those contacts being in person with the individual being served. ACT-I (High Intensity) operations require ten hours of team active operations during weekdays and four hours per day on weekends and holidays along with an on-call worker from the ACT team 24/7 for client emergencies to triage with crisis workers. This program is composed of various mental health professionals, licensed and non-licensed, to include a team lead, who is required to be a licensed professional, registered nurse(s), certified/licensed clinician(s), certified/licensed substance use disorder specialist, vocational specialist, and CPST/case manager(s). Each team allows for additional flex positions depending on the team needs.

ACT-II level of service needed is when an individual may not require the ACT-I (High Intensity) level of support and would benefit from the team-based approach. ACT-II provides five or more contacts per month, with a minimum of three of those contacts being in person with the individual being served. ACT-II operations require eight hours of team active operation during weekdays. These programs are composed of various mental health professionals, licensed and non-licensed, to include a team lead, who is required to be a licensed professional, registered nurse(s), certified/licensed clinician(s), certified/license substance use disorder specialist, vocational specialist, and CPST/case manager(s). Each team allows for additional flex positions depending on the team needs.

Assertive Community Treatment Young Adult (ACT-YA) level of service is needed for individuals who are 15-26 years old who are having impaired functioning in the community, that require continuous high service, that have not been met by the traditional outpatient setting. ACT-YA provides eight or more contacts per month, and at least four of those contacts must be provided in person with the individual being served. ACT-YA operations required ten hours of team active operation during weekdays and four hours per day on weekends and holidays along with an on-call worker from the ACT team 24/7 for client emergencies to triage with crisis workers. This program is composed of various mental health professionals, licensed and non-licensed, to include a team lead, who is required to be a licensed professional, registered nurse(s), certified/licensed clinician(s), certified/license substance use disorder specialist, vocational specialist, and CPST/case manager(s). Each team allows for additional flex positions depending on the team needs.

High Acuity Services and supports are available to children and youth up to age 18 who meet eligibility for high acuity services. The goal of High Acuity Services is to stabilize children and youth at home and in the community who are at risk of being admitted to more intensive programs or to support children and youth transitioning from such facilities back into the community. These services are designed with an emphasis on family involvement, empowering caregivers, and addressing key issues related to the child/youth's behavioral health challenges. The long-term aim is to prepare the child/youth for a transition to less intensive, longer-term outpatient treatment to achieve sustainable positive outcomes. Services are typically provided 2-3 times per week, with an average treatment duration of 12-16 weeks, and a minimum of 10 hours per month which should allow for evening and/or weekend hours to accommodate family schedules.

Adults and children not enrolled in high acuity or SUD population, are eligible to receive services, as needed, to help manage their short-term acute needs and ongoing management for behavioral health needs. 'As needed' services include targeted case

management services, psychiatric rehabilitation services, peer support services, outreach and engagement. Adults and children have access to both office-based and community-based services based on individual needs and treatment plans.

Each CCBHC is required to provide evidenced based practices (EBPs), to include Assertive Community Treatment (ACT), Individual Placement and Support (IPS), Seven Challenges, Mobile Response and Stabilization Services (MRSS) and Zero Suicide. In addition, CCBHCs have staff trained to provide Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), Family Psychoeducation (FPE) Medication Assisted Treatment (MAT), Screening, Brief Intervention and Referral to Treatment (SBIRT), 12 Step, and Trauma informed care.

CCBHCs are required to be open for a minimum of 50 hours each week and offer designated Open Access hours at least three days per week. This Open Access provides availability for client walk-ins and same-day appointments. Furthermore, CCBHCs must educate all staff members about the availability of these Open Access services. CCBHCs shall have staff dedicated staff for outreach and engagement who do not carry a caseload along with having Care Coordination Agreements.

In addition to the above teams having a substance use disorder specialist, CCBHCs have certified peer recovery specialists as flex positions within the agency which provide recovery supports individually or in a group setting. Peer services include peer-run wellness and recovery centers; adult/youth/young adult peer support; recovery coaching; peer-run crisis respites; warmlines; peer-led crisis planning; peer navigators to assist individuals transitioning between different treatment programs and especially between different levels of care; mutual support and self-help groups; peer support for older adults; peer education and leadership development; and peer recovery services. General outpatient services are provided which include treatment, counseling, and medication management services to treat substance use disorder and individuals in recovery. Counseling services can be offered individually or in a group setting utilizing EBPs. Medication assisted treatment is used to treat opioid use disorder, alcohol use disorder, and tobacco use disorder in conjunction with behavioral health treatment. Intensive Outpatient Programs (IOP) are offered that specialize in the treatment of substance use disorders and co-occurring diagnoses. IOP utilizes EBPs and harm reduction strategies to provide individuals with more intensive support and therapy than traditional outpatient services, while allowing people to maintain a level of independence and continue with their daily living activities.

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 use prevention and SUD treatment services	(●) Yes ( ) No
h)	Medical and dental services	(●) Yes ( ) No
i)	Recovery 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

Case management services are provided within the three Assertive Community Treatment programs (ACT-I, ACT-II, ACT-YA). Outpatient mental health and substance use services involve case management services along with high acuity children's services. Targeted case management services assist people receiving services in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports. Targeted case management also provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all people served. Targeted case management include supports for people deemed at high risk of suicide or overdose, particularly during times of transitions such as from a residential treatment, hospital emergency department, or psychiatric hospitalization. Targeted case management is also used during other critical periods, such as episodes of homelessness or transitions to the community from jails or prisons. Targeted case management is used for individual with complex or serious mental health or substance use conditions and for

individuals who have a short-term need for support in a critical period, such as an acute episode or care transition. Case management ensures that services align with the individual's treatment plan, addressing their wellness and recovery goals. Follow-up and monitoring involve communication with the client, family, service providers, and other involved parties.

4. Describe activities intended to reduce hospitalizations and hospital stays.

The state's crisis system is intended to reduce hospitalizations and hospital stays. BH Link is the state's crisis receiving and stabilization center which assists with emergency room diversion and coordination to an appropriate level of care. Within the state, there are also two crisis stabilization units and one acute stabilization unit that assist with reducing hospitalizations. 988 Lifeline connects people to appropriate care and resources when they or someone they care about is experiencing a behavioral health crisis.

Emergency Services, mobile crisis, and mobile response and stabilization services (MRSS) are provided 24/7 to adults and children in response to behavioral health and substance use crisis to provide an appropriate referral, if needed, either through CCBHCs or other agencies. In addition, the ACT programs and high acuity services at CCHBHCs assist with decreasing hospitalizations by providing intensive services.

5. Please indicate areas of technical assistance needs 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

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health 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	53,136	441 per 100,000 per year
2.Children with SED	10,659	443 per 100,000 per year

2. 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 2022-2023 NSDUH estimate for adults aged 18+ with SMI in Rhode Island, 5.98%. This percentage was multiplied by SAMHSA's population estimate of adults aged 18+ in RI based on 2023 URS reports, 888,564 people.

Statewide incidence of SMI was calculated using 2024 data from BHOLD. From January to December of 2024, there were 3,996 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 2024 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 2023 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 2024 who were enrolled in an MH program and did not have a prior admission in BHOLD. This number, 916, was divided by the 2024 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.

3. Please indicate areas of technical assistance needs related to this section.

N/A

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

a)	Social Services	◉ Yes	○ No
b)	Educational services, including services provided under IDEA	◉ Yes	○ No
c)	Juvenile justice services	◉ Yes	○ No
d)	Substance use prevention 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

2. Please indicate areas of technical assistance needs related to this section.

N/A

[1] *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.*

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 tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

There are eight CCBHCs that are certified by service area that align with the catchment areas designated. The catchment areas are mapped out to provide statewide services. The state's mobile crisis model has expanded services though the state as part of CCBHC. There are also other agencies within these areas thate outside of the community-based model.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

The state has the Projects for Assistance in Transition from Homelessness (PATH) grant with one provider that covers the state. A few activities are outreach, case management, providing SOAR, and handoffs to health services. The state has the Treatment for Individuals Experiencing Homelessness (TIEH) with three providers that are CCBHCs. The providers develop a partnership with a shelter or public housing authority in their catchment area. A few activities are outreach, engagement, and connection to behavioral health treatment, case management, recovery support services, and housing services. Open Doors is an agency that provides wrap-around support and advocacy for justice-involved and homeless people that strengthens communities and increases public safety. Open Doors can assist with vital records, applications, employment, and housing. CCBHCs are also required to have Care Coordination Agreements with a home stabilization provider and agencies with SOAR-trained individuals.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

RI Office of Healthy Aging (OHA) connects older adults to information and resources in the community along with advocating for laws, policies, and investments that protect their rights. There are also trainings for older adults through OHA. There is a Long-term Care Coordinating Council (LTCCC) that is convened by the Office of the Lieutenant Governor. The LTCCC was established to develop and coordinate state policy concerning all forms of long-term care for seniors and person with chronic disabilities or illnesses. CCBHCs either provide direct services to the older adult population or connect to resources through partnerships.

d. Please indicate areas of technical assistance needs related to this section.

N/A

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] **https://www.samhsa.gov/resources-serving-older-adults**

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

1. Describe your state's management systems.

The BHDDH funds a percentage of the Behavioral Healthcare Division through the Block Grant which involves fiscal, programming, contract monitoring, and the data and monitoring unit. The staff are involved in the implementation of the plan. There's a Block Grant Planner and Block Grant Administrator that are dedicated to the plan and reporting. The fiscal unit is responsible for processing invoice and budget reports. The programming staff focus on the scope of work regarding tasks and deliverable. The contract monitoring staff review invoicing and assist with contract budgeting to ensure compliance. The data unit assists with the identification and analysis from the state's MMIS, BHOLD, and dashboards.

The state has multiple training and technical assistance contracts that focus on providing education and training to the workforce. The trainings are designed to meet the requirements for certification and licensure in the state and the continuum of care. There are trainings that are focused on EBPs, fidelity, and community interest.

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 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 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 federal resource guide **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.**

2. 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.

Telehealth in RI started as an emergency response to Covid. It allowed individuals to continue to receive services versus having to gaps in services or disengagement. RI Medicaid and private insurers provide telehealth visits via telephone or audio-video enabled devices. Telehealth is part of treatment service delivery; however, it cannot be the only modality for treatment service delivery. RI utilizes telehealth for screening, assessment, treatment, case management, and crisis services. It has helped with avoiding a delay of services, avoiding gaps in services, and allowing for flexibility that enhances the service delivery.

3. Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for 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 (with medications for addiction treatment included in v-x):

i)	Screening	◉ Yes	○ No
ii)	Education	◉ Yes	○ No
iii)	Brief intervention	◉ Yes	○ No
iv)	Assessment	◉ Yes	○ No
v)	Withdrawal Management (inpatient/residential)	◉ Yes	○ No
vi)	Outpatient	◉ Yes	○ No
vii)	Intensive outpatient	◉ Yes	○ No
viii)	Inpatient/residential	◉ Yes	○ No
ix)	Aftercare/Continuing Care	◉ Yes	○ No
x)	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. Does your state 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.

96.131 Treatment services for pregnant women is noted in Addendum D in the contracts. This includes interim service requirements. All contracts are monitored monthly for compliance based on SUPTRS BG requirements along with assigned tasks and deliverables. The State also contacts agencies anonymously to engage in treatment to ensure compliance. If an agency is found to not be complying, the State contacts the agency CEO to discuss the extent of the concern. Based on the findings, a corrective action plan could be 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)** Monitoring requirements as outlined in the authorizing **statute** and implementing **regulation**? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Electronic system with alert when 90 percent capacity is reached? (●) Yes ( ) No
- **b)** Automatic reminder system associated with 14-120 day performance requirement? (●) Yes ( ) No
- **c)** Use of peer recovery supports to maintain contact and support? (●) Yes ( ) No
- **d)** Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? (●) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

96.126 Capacity of treatment for intravenous substance abusers is noted in Addendum D of the contracts. This includes interim service requirements. All contracts are monitored monthly for compliance based on SUPTRS BG requirements along with assigned tasks and deliverables. The State also contacts agencies anonymously to engage in treatment to ensure compliance. If an agency is found to not be complying, the State contacts the agency CEO to discuss the extent of the concern. Based on the findings, a corrective action plan could be established.

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.

96.127 Requirements regarding tuberculosis is noted in Addendum D of the contracts along with the Rules and Regulations for Behavioral Healthcare Organizations

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

Hypodermic Needle Prohibition

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 for the purpose of injecting illicit substances **(42 U.S.C.§ 300x-31(a)(1)(F))**? ◉ Yes ○ No

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 members, veterans, tribal entities, older adults, persons experiencing homelessness)? ( ) Yes (●) No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered 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 system, adult criminal justice system, 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

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.

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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)

JACHO, CARF, COA

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

If the answer is No to any of the above, please explain the reason.

Performance-based accountability has not been something we have made available to operating direct care staff. Some organizations privately offered training but nothing statewide.

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[1] (TTCs)?

a) Prevention TTC? ◉ Yes ○ No

b) SMI Adviser ○ Yes ◉ No

c) Addiction TTC? ◉ Yes ○ No

d) State Opioid Response Network? ◉ Yes ○ No

e) Strategic Prevention Technical Assistance Center (SPTAC) ○ Yes ◉ No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C.§ 300x-22(b)**,**300x-23**,**300x-24**, and **300x-28** (**42 U.S.C.§ 300x-32(e)**).*

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women (300x-22(b)) ○ Yes ◉ No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23) ○ Yes ◉ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (**42 U.S.C. § 300x-28**)

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/SubChapter/212-10-10

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[1] **https://www.samhsa.gov/technology-transfer-centers-ttc-program**

Footnotes:

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

   Our primary data collection and reporting system is the Behavioral Health On-Line Database (BHOLD), an online portal required to be used by all state-licensed behavioral health facilities. Providers submit client enrollment data (including admissions, discharges, and updates) through this system. BHOLD supports data analysis at multiple levels, including client, program, and provider. Additionally, it enables reporting by demographic characteristics, geographic regions, and other relevant groupings.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

Our data collection system is specific to mental health and substance use disorder services. While BHOLD is limited to these behavioral health populations, we do use it to link with the state's Medicaid Management Information System (MMIS), which is maintained and managed by another state agency. It should be noted that our BHOLD system collects data for all clients regardless of insurance type.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

We regularly perform data linkages with the Medicaid Management Information System (MMIS) and receive a daily feed of arrest and intake data from the state's Adult Correctional Institution. Additionally, through the state's integrated data ecosystem, managed by another agency, we access deidentified data related to wages, employment, and Temporary Disability Insurance (TDI) for our health home populations. We also collect hospital data through separate mechanisms, including aggregate-level information on wait times and bed availability and identified data regarding step-down care options for hospitalized individuals. Currently, we do not have linkages to juvenile justice or education data systems.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

The state is actively working with providers to improve and standardize the collection of evidence-based practice (EBP) data. Currently, providers submit data quarterly using a reporting template. While this remains an area of ongoing development, we are working to ensure consistent data collection practices across providers.

5. Briefly describe the limitations of the SMHA 's existing data system.

Key limitations of the current data system include challenges with reporting change over time (i.e. decrease in reported substance use, changes to employment/housing), limited system logic and branching to guide accurate data entry, and a lack of functionality for providers to access and generate their own reports. Additionally, the system has minimal capacity for bulk data import, resulting in significant manual data entry for many providers.

6. What strategies are being employed by the SMHA to enhance data quality?

We are currently working with a new vendor to implement a data collection system designed to significantly enhance data quality. The new system will include longitudinal reporting capabilities, logic and branching to support accurate data entry, bulk data import functionality for all providers who request it, and built-in Power BI dashboards that allow providers to view their caseloads and monitor outcomes in real time.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

Unfortunately, funding is always an issue for IT systems and State procurement policies don't always allow for the best vendor to be selected.

8. Please indicate areas of technical assistance needs related to this section.

It would be useful to know what other states are doing to increase their data quality as well as how they are working with state agencies in their states to make connections to other data sources, such as Education and Criminal Justice.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within 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 evidence-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 fund 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 expending 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 has 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.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, 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 services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, 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 the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

Crisis Call Center: Rhode Island has one 988 Lifeline Center that serves the entire state. It is run by Horizon Healthcare Partners (HHP) involving a partnership with BH Link and Community Care Alliance (CCA). 988 Suicide and Crisis Lifeline calls are answered by trained crisis counselors at BH Link, the state's 24/7/365 crisis receiving and stabilization center for mental health and substance use disorders. People in need can also text and chat the 988 Lifeline 24/7/365. 988 Lifeline connects people to appropriate care and resources when they or someone they care about is experiencing a behavioral health crisis. 988 Lifeline continues to answer crisis calls from 414-LINK which is operational but no longer promoted due to 988 Lifeline. HHP also operates the RI Hope and Recovery Line at 942-STOP which provides access for state-funded recovery housing

involving joining the recovery housing waitlist and financial support. 942-STOP also answers calls from 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, Kids' Link behavioral health referral network, Coordinated Entry line for emergency shelter needs, the 24-hour domestic violence helpline operated by Blackstone Valley Advocacy Center, and the Aging and Disability Resource Center.

Crisis Mobile Response: Children's Mobile Response and Stabilization Services (MRSS) helps to stabilize and maintain children in the least restrictive setting and to prevent placement disruptions of children/youth that result in unnecessary hospitalization or other out of home placements. Tides and Family Services of Rhode Island (FSRI) are the two agencies that provide 24/7/365 intervention and support for children (ages 2-21) across the state experiencing behavioral health crises. These agencies work with 988 Lifeline, schools, hospitals, and PCPs, etc. These agencies have Designated Collaborating Organization (DCO) relationships with the Certified Community Behavioral Health Clinics (CCBHCs), as mobile crisis is a required service. There are eight CCBHC locations in the state.

Each CCBHC has emergency service departments which include a 24/7/365 staffed emergency line and 24/7/365 mobile crisis teams for their designated catchment area. CCBHC's mobile crisis teams respond to behavioral health and substance use crisis for both adults and youth, utilizing a 2-person mobile crisis response and the MRSS model for youth. Currently about 91% of Rhode Island is covered by CCBHC mobile crisis response for adults, and 100% of Rhode Island is covered with MRSS mobile crisis response for Youth. Mobile crisis teams can be accessed by calling the CCBHC directly, or through 988 who works with each CCBHC to provide warm handoffs if a call indicates a possible in-person response. Each CCBHC also works with police and law enforcement in their catchment area to provide a mobile co-response if indicated.

Crisis Receiving and Stabilization Centers: Rhode Island has one 23 bed crisis receiving center which is BH Link. BH Link is a 24/7 community-based walk-in or drop-off facility where clinicians connect people to immediate, stabilizing emergency behavioral healthcare services, and long-term care and recovery supports. BH Link helps to ensure all Rhode Islanders people18+ experiencing mental health and substance use crises receive the appropriate services they need as quickly as possible in an environment that supports their recovery. Services are provided by nurses, counselors, psychiatrists, phone screeners, and peer specialists. BH Link partners with municipalities and mobile crisis teams to ensure that services are available statewide.

Rhode Island has three 24-hour, short stay crisis stabilization units.
1.) Elwyn has a crisis stabilization unit that provides short-term care for individuals who are experiencing a behavioral health crisis and/or are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the individual's home and community environment without onsite supervision. There are respite beds available for individuals whose insurance doesn't cover admission until they're connected with other supports or stabilized.
2.) Community Care Alliance (CCA) has an acute stabilization unit that provides short-term hospital step-down and emergency room diversion. CCA provides assessment, medication management/detoxification for MH/SUD, and linkage to treatment services and community referrals.
3.) The Providence Center (TPC) has a crisis stabilization unit that provides short-term care for individuals experiencing an acute psychiatric and/or substance use crisis that could escalate to a point of requiring hospitalization. TPC's CSU is location on the campus of Butler Hospital. These are respite beds available for individuals whose insurance doesn't cover admission until they're connected with other supports or stabilized. Emergency departments also provide services to individuals experiencing mental health and substance use crises.

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 published 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 published 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.*

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 contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☑	☐
Safe place to be	☐	☐	☐	☐	☑	☐

3. Briefly explain your stages of implementation selections here.

Someone To Talk To: RI's 988 Lifeline Center serves the entire state. 988 Lifeline offers 24/7 call, text, and chat access from trained crisis counselors who can help people experiencing suicidal, substance use, and mental health crisis, or any other kind of emotional distress. RI's call answer rates remain in the high 90th percentile. Outside of 988, each CCBHC has a 24/7 staffed emergency line that receive crisis calls from the community. Each CCBHC is required to have a care coordination agreement with 988 and have developed warm handoff protocols for 988 calls requiring a mobile crisis response from a CCBHC or DCO providing youth MRSS mobile crisis response.

Someone To Respond: Statewide mobile crisis has been implemented 24/7/365 through a variety of agencies and partnerships within the state. There are currently 8 CCBHCs operating in Rhode Island which covers 90% of the state of Rhode Island. Each CCBHC is required to have 24/7/365 mobile crisis response capacity for adults and youth in their catchment area. Each CCBHC is responsible for providing 24/7/365 2-person mobile crisis response for adults and children, and each CCBHC is required to provide children's mobile crisis via the MRSS model. For the one catchment area that does not have an active CCBHC, there is a grant funding MRSS mobile crisis response for youth.

A Place to Go: BH Link is the only 24/7/365 crisis receiving and stabilization center in RI, with the ability to hold individuals for 23 hours to assist in emergency room diversion. Rhode Island emergency departments, emergency respite programs and crisis stabilization short stay units also assist with supporting individuals with behavioral health crisis. Each CCBHC is required to have open access and extended hours which assists individuals with access to services up to 8pm in most areas.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

RI will continue to review data on mobile crisis response and service utilization of our current crisis system components to plan for future developments and initiatives. We currently are in procurement stages of a crisis tech platform to assist with mobile crisis dispatch, real time access to appointments and bed availability in an effort to streamline our adult and youth crisis response and create a comprehensive, cost-efficient crisis systems.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 1
   ii. Not in the suicide lifeline network: 0

b. Number of Crisis Call Centers with follow up protocols in place
   i. In the 988 Suicide and Crisis lifeline network: 1
   ii. Not in the suicide lifeline network: 0

c. Estimated percent of 911 calls that are coded out as BH related: 0

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 public safety first responder structures (police, paramedic, fire): 8
b. Integrated with public safety first responder structures (police, paramedic, fire): 7
c. Number that utilizes peer recovery services as a core component of the model: 7

Safe place to be

a. Number of Emergency Departments: 11
b. Number of Emergency Departments that operate a specialized behavioral health component: 10
c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 1

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

For MHBG, the 5% crisis set aside planned activity is BH Link. For BSCA, the 5% crisis set aside planned activity is 988 Lifeline Center. Currently over 90% of the State of RI is covered by CCBHC services, with the plan to add an additional CCBHC in the remaining catchment area to ensure 100% coverage. Each CCBHC is required to have 24/7 mobile crisis response capability and a care coordination agreement with 988. Each CCBHC met with 988 leadership to develop protocols for referrals for CCBHC services and/or mobile crisis response if indicated. Future goals include the procurement of a crisis data platform that will allow real time dispatch of mobile crisis teams directly from 988 for a streamlined mobile crisis approach throughout the state.

7. Please indicate areas of technical assistance needs related to this section.

N/A

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5c. Estimated percent of 911 calls that are coded out as BH related is unknown due to not having access to 911 data.

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of 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 health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical 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 a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

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, there are 10 identified 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 **Working Definition of Recovery.**

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 several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs 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 behavioral health treatment system.

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 funds for recovery support services? (●) Yes ( ) No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health 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 and recovery support services for adults with SMI and children with SED are provided by multiple agencies in the state. CCBHCs have staff trained in the Housing First evidence-based practice and they have partnerships with housing agencies. There are two homeless outreach programs through discretionary grants (PATH and TIEH) and outreach and engagement through CCBHCs. A person-centered plan is developed and implemented with each person served. Recovery Friendly Workplace has around 180 workplaces that have earned designation which empowers workplaces to provide support for people recovering from substance use disorder and mental health challenges. All CCBHCs shall be designated as a Recovery Friendly Workplace. Individual Placement Supports (IPS) is a required evidence-based practice at CCBHCs along with staffing of vocational specialists. There is a peer specialist training through an entity or through approved TOTs along with peer specialist certification. Certified peer recovery specialists are part of CCBHC staffing and multiple other agencies. There are five current Recovery Community Centers (RCCs) across the state that provide recovery support services, organize recovery activities, and provide education and outreach programs located throughout the state.

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 and recovery support services for individuals with substance use disorders are provided by multiple agencies in the state. There are nine contracted Recovery Houses agencies which total 41 houses and an open request for proposal (closes August 18) to add new houses. The state provides financial support for recovery housing through two different grants available to residents – the 1-year grant and the 6-month booster grant. There are five current Recovery Community Centers (RCCs) across the state that provide recovery support services, organize recovery activities, and provide education and outreach programs located throughout the state. A request for proposals to add up to three new recovery community centers in high-need areas is about to post as well. RI residents can receive Naloxone through a harm reduction organization, shipped to their residence, or from a pharmacy. There are two homeless outreach programs through discretionary grants (PATH and TIEH) and outreach and engagement through CCBHCs and recovery community centers. Recovery Friendly Workplace has around 180 workplaces that have earned designation which empowers workplaces to provide support for people recovering from substance use disorder and mental health challenges. All CCBHCs shall be designated as a Recovery Friendly Workplace. RI is in the process of developing Collegiate Recovery programs at Rhode Island College and University of Rhode Island and has procured technical assistance with the Association of Recovery in Higher Education to support these two institutions as well as any other Rhode Island-based institution of higher education to receive support in developing a collegiate recovery program. Through a relationship with C4 Innovations Inc., we have retooled core peer recovery specialist trainings including the fundamental 46-hour long peer recovery specialist training, the peer recovery specialist supervisor training, and an advanced recovery ethics training. Each has training-of-trainers opportunities to parallel these trainings to ensure sustainability but our training vendor, C4 Innovations Inc., is also compensated to offer a training array that can be found on C4's Rhode Island Behavioral Health Training website. Certified peer recovery specialists are part of CCBHC staffing and multiple other agencies that must be certified by the department before Medicaid will allow billing of peer-based recovery support services.

5. Does the state have any activities that it would like to highlight?

We improved several processes around waitlist management, state site visits, certification, training availability, and consumer complaints for our recovery housing system over the last year. With this new request for proposals, our hope is to bring down the waitlist which currently is between 40-50 individuals for almost a month down to immediate access if possible. Next, we intend to work on the quality of the recovery wellness plans required in recovery housing and try and find a way for those plans to follow clients from treatment through recovery housing through engagement with recovery community centers.

Through engagement with the Governor's Overdose Task Force's recovery workgroup, it's been highlighted that training on the role of the peer recovery specialist would benefit an array of behavioral health professionals, so this has been added to C4 Innovations Inc.'s scope of work this year.

6. Please indicate areas of technical assistance needs related to this section.

We could use assistance with data collection improvement for recovery service providers.

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Environmental Factors and Plan

11. 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 disorder 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 using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 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 use, 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, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model 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, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to 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 functioning of children, youth and young adults in home, school, and community settings. 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 on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. 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:

1. 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);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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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 use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: 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**

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 use 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 Early Serious Mental Illness (ESMI) services? ◉ Yes ○ No

d) Is the state providing trauma informed care? ◉ Yes ○ No

6. Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

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 Plan for Children and Youth".

"Rhode Island's Behavioral Health System of Care Plan for Children and Youth" envision a partnership among communities, youth, families, schools, pediatricians, government, and provider agencies that improves outcomes, increases access to services as supports, and promotes positive changes in the lives of children and their families.

The program components are prevention, mobile response and stabilization services, service array, and care coordination. The goal for prevention is defining prevention in the children's behavioral health system of care, strengths of prevention, opportunities to strengthen prevention, and needs of prevention. Another goal is to ensure a responsive Children/Family Mobile Crisis function within the system, aligned statewide with other crisis response functions. Developing and expanding services and supports based on the System of Care philosophy and approach by ensuring investments in an adequate, responsive, and broad service array is a program component, along with expanding intensive care coordination.

The foundational components are working transformation, outreach and education, and sustainable and braided funding. Workforce development partnerships between behavioral health provider agencies and educators to develop and offer training, education, experiential learning, and career awareness programs that recruit and prepare students and job seekers for jobs and careers is component. The goals of outreach and education are to share information with families, create a community network for community leaders to engage, provide awareness of how the System of Care can help families, and create a feedback loop.

The connector components are single point of access and data systems for outcomes measurement. The goal of single point of access is to provide a more organized pathway to service supports to develop an easy and streamlined way for children and their families to access the behavioral health system regardless of a family's financial resources of insurance status. Another goal is to develop a set of holistic, child-, family- and system-focused metrics to track, evaluate, and adapt the System of Care along with developing and facilitating a process of integrating the insights into our collective body of work on a regular basis.

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

DCYF has released "Setting P.A.C.E for Rhode Island Children and Families 2025-2030 Strategic Plan". The Strategic Plan is anchored in four core pillars—Prevention, Accountability, Collaboration, and Engagement (P.A.C.E.)—essential for achieving lasting outcomes for Rhode Island's children and families. Prevention focuses on proactive measures to strengthen families, prevent out-of-home placements, and address underlying challenges before crises occur. Accountability builds transparency, data-driven practices, and a culture of continuous improvement to ensure DCYF upholds the highest standards of service. Collaboration enhances partnerships across agencies, providers, and the community to support a unified approach to child and family well-being. Engagement actively involves families, youth, and community members in service planning and decision-making to foster trust and shared responsibility. The DCYF Resource Guide – Home Based Services was updated in March 2025. DCYF's array of services include mental health and disruptive behavior services, family stabilization and prevention services, parent skill building services, kinship, foster care and adoption services, family visitation, and aftercare and transitional services. DCYF is currently working with EOHHS to create a Medicaid bundled rate for some of the service array.

Through CCBHC, RI is enhancing access to children's services to include mental health and substance use services. Mobile Response Stabilization Services (MRSS) is also provided to children up to age 18 through CCBHC.

Seven Challenges for adolescents 12-17 is a required evidence-based practice through CCBHC. Seven Challenges is also implemented at other community health provider agencies, private practice offices, and the training school.

EOHHS is implementing a Community Based Intensive Care (CBIC) program through a SAMHSA grant. CBIC clients receive intensive in-home service to avoid hospitalization through multiple partnerships. CBIC has access to outreach workers, respite care, and nursing and psychiatric services.

8. Please indicate areas of technical assistance needs related to this section.

N/A

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12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

The Suicide Prevention Strategic Plan focuses on the following priorities and goals to achieve and sustain substantial reductions in suicide. 1.) Strengthen economic supports 2.) Create protective environments 3.) Improve access to delivery of suicide care 4.) Promote healthy connections 5.) Teach coping skills and problem-solving skills 6.) Identify and support people at risk 7.) Lessen harms and prevent future risk 8.) Build Rhode Island's suicide prevention infrastructure

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? (●) Yes ( ) No

If yes, please describe how barriers are eliminated.

Priority 6, Goal 3: Plan for safety and follow-up after an attempt focuses on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments by focusing on the following 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:
o 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.
o 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 Emergency Medical Services (EMS) runs and emergency department visits for attempted suicides to deploy outreach workers for follow-up

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

The Suicide Prevention Advisory Committee started in April 2024 that typically meets every other month. The Suicide Fatality Review Team started in April 2025 and will be convening on a quarterly basis with focused, data-driven themes. Each meeting will consist of a review of cases, allowing the team to bring forward and agree upon recommendations aiming to ultimately reduce the burden of suicide death in our state. RIDOH's Comprehensive Suicide Prevention Grant team is seeking to learn more about how adult males, aged 18 or older, engage in conversations about mental health and resources that could assist them in addressing mental health issues. The team is currently administering the Men's Mental Health survey to collect this information.

6. Please indicate areas of technical assistance needs related to this section.

N/A

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Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, 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 justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- 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.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. 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?

N/A

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 collaborates with other state agencies and community partners regularly. We provide interagency support to our partners at Executive Office of Health and Human Services (EOHHS), Department of Health (DOH), Department of Children, Youth and Family (DCYF), Office of Health Aging (OHA) and Department of Corrections (DOC) on various programs and projects to increase awareness in the community and connection to individuals served across agency programs. Recently our state initiative on CCBHC has created an interagency team which meets weekly to discuss coordination with community providers such as school departments, social service agencies, primary care, hospitals, community task forces and advisory councils. We collaborate both internally with our state departments as well as externally with community providers to ensure access to BH and SUD service and identify gaps in services based on community needs. Current interagency efforts are data driven, quality focused and engaged to coordinate state agencies to coordinate systems of care.

4. Please indicate areas of technical assistance needs related to this section.

N/A

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

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 assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual 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 advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

URI is the facilitator of the Block Grant Needs Assessment (BGNA). On August 1st, 2024, URI conducted a focus group at the council. On January 8th, 2025, there was a written departmental update regarding the BGNA provided to the council prior to the January 9th, 2025, meeting on the BGNA. There were no questions asked by the council. On June 12th, 2025, URI presented at the council on the BGNA. The presentation reviewed the following: BGNA goals, needs assessment participants, secondary data analysis, and some results from the survey, focus groups, and key informant interviews. Council questions were asked and answered at the meeting and additional follow-up was via email. On July 17th, 2025, the BG Planner presented at the council on the FY26 SUPTRS BG and MHBG Application/Plan. Agenda items were council composition, overview and general purpose, highlights of the application, program changes, funding compliance, and supplemental funding. Council questions were asked and answered at the meeting and additional follow-up was via email.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan ○ Yes ◉ No

b. State Report ○ Yes ◉ No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

There are monthly meetings held at the Governor's Council of Behavioral Health.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? ◉ Yes ○ No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) ◉ Yes ○ No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Rhode Island Governor's Council on Behavioral Health is the State's behavioral health planning council. It was established by both federal and State law to review and evaluate the needs and problems associated with Rhode Island's services for individuals with mental health and substance use disorders.

The Council promotes and monitors the development, coordination, and integration of state-wide behavioral health services. The Council also serves in an advisory capacity to the Governor and the General Assembly.

The Governor's Council has both statutory and public members. The public members may be behavioral healthcare service providers, consumers of these services, their family members, individuals in recovery from mental illness or substance use

disorders, behavioral healthcare advocates or other interested parties. More than half of the members must be consumers of behavioral healthcare services, their family members, advocates or others.

The meetings are open to the public and held monthly.

7. Please indicate areas of technical assistance needs related to this section.

N/A

Footnotes:

STATE OF RHODE ISLAND

Governor's Council on Behavioral Health

14 Harrington Road
Cranston, RI 02920

Tel: (401) 462-1550
Email: Tia.Micek@bhddh.ri.gov

Governor's Council Report – January 9, 2025

BHDDH Updates – Tom Martin

Contracts and Grants:

1. Please be sure to update your contact person in ECivis to receive funding notifications from BHDDH.
2. Providers may request a budget change at any time during an active contract. The time frame for the request must be for the next month of a contract and not for a previous month(s) of the contract.

Planning

Substance Use and Mental Health Block Grant Needs Assessment

Update to the Governor's Council on Behavioral Health by the University of Rhode Island (URI)

In response to valuable feedback from the Council, this Block Grant Needs Assessment (BGNA) cycle, we refined our approach to include perspectives from individuals who are not currently receiving substance use (SU) or mental health (MH) services, yet need them. This provides us with a more well-rounded understanding of the Rhode Island community. We are close to completing data collection for the 2024-2025 BGNA and plan on presenting the findings to the Council in July.

As of mid-December, we have collected nearly all data for the BGNA. Having completed nine focus groups throughout the state, we are analyzing the data for common, salient, and relevant themes. Our four key informant interviews with appropriate experts and stakeholders are complete and we have one final interview scheduled.

Additionally, we conducted rigorous secondary data analysis using national and local reports to inform the BGNA. Leveraging national datasets allowed us to explore comparisons between Rhode Island, our neighboring New England states, as well nationwide trends, on outcomes such as rates of substance use disorders, tobacco use, and other relevant issues. Local reports and data sets, such as the RI Kids Count 2024 report and Prevent Overdose RI data, have been utilized to explore local needs more deeply.

Finally, an online community survey collected responses from Rhode Island community members from April 2024 through January 1, 2025. As of December 20th, 366 individuals have completed 100% of the survey. Of these individuals:

- 90 are providers of services
- 144 are receivers of services
- 104 are family members of individuals who received services
- Seven individuals have not received services, and
- 21 are individuals who do not identify as any of the previously mentioned roles (these folks may overlap with multiple roles, such as a service provider who also receives MH or SU services, etc.). We will begin survey data analyses in the coming weeks.

We remain grateful for the ongoing input and insights from the Governor's Council on Behavioral Health. The Council plays a critical role in this process and ensures that our methods align with the ever-evolving substance use and mental health landscape in our Rhode Island community.

Substance Use Treatment Unit:

- BHDDH has been working closely with RI Hospital Medical staff, as well as with the medical staff from all of RI's Opioid Treatment programs, to ensure proper care coordination to begin implementing the new federal DEA rule allowing Emergency room staff to provide single dose inductions of methadone, but with the understanding that Emergency room staff can also dispense 3-days' worth of medication at discharge. The meetings planned were to ensure that the individual beginning on methadone had a clear and seamless way to connect to their local OTP for continued services. Care Coordination included problem solving for weekend and evening inductions.
- January is deemed "National Treatment Month" by our federal partners at SAMSHA. The focus is on how to support Substance Use Treatment and ways to reduce stigma. Stigma keeps people from accessing the substance use disorder treatment that could save their lives—as a provider or a supporter of treatment, anyone can make a difference by spreading awareness that treatment works, and recovery is possible. More information can be found here Substance Use Disorder Treatment Month | SAMHSA

Mental Health Treatment Unit

- The Mental Health Unit hosted the first meeting of the Supported Employment Learning Collaborative which has been developed to provide technical assistance and training to provider agencies implementing Individual Placement and Support (IPS). This collaborative will be offered twice per month.

- The Work4Wellness Statewide Supported Employment Taskforce, will be hold the next quarterly meeting on January 21, 2025 from 11:00-12:00pm. If you are

interested in learning more information about these initiatives, please reach out to Natalie Laroche at Natalie.Laroche@bhddh.ri.gov

Special Projects

- Rhode Island was selected to participate in SAMHSA Crisis Policy Academy to review our current crisis system in alignment with SAMHSA's best practice for crisis

Prevention and Recovery

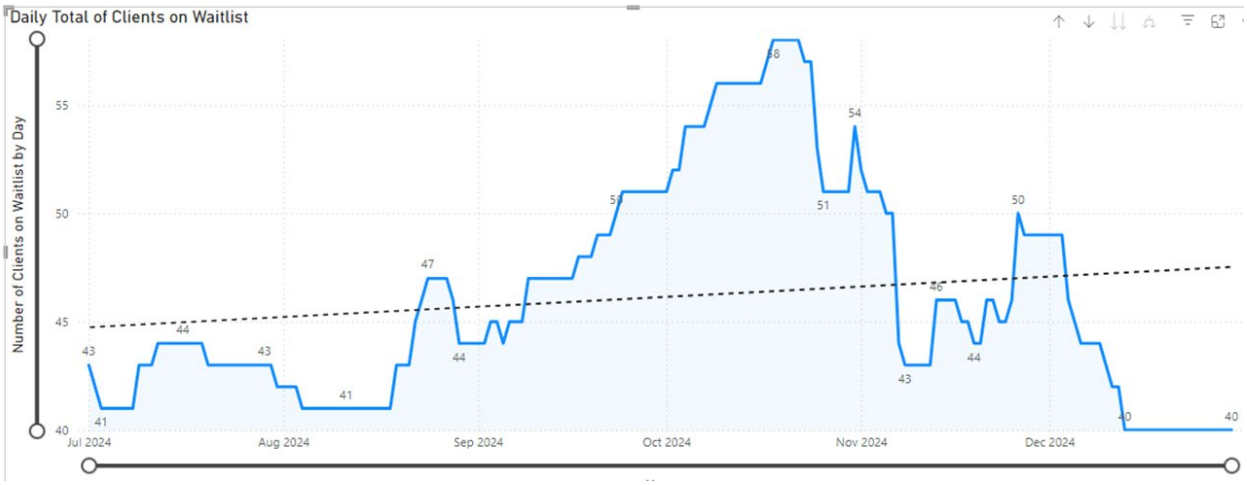
- Back in November 2024, the Teen Institute program was designated a Level III evidence-based program in the state of Rhode Island per the RI Evidence-Based Practices Workgroup. The RFP to deliver this program and enhancements closed on January 5, 2025, and the review of applications will begin this week.
- The next 46-hour Certified Peer Recovery Specialist Training is scheduled to be held by C4 Innovations Inc. from February 20, 2025, to February 28, 2025 (not including weekends). Location and more details to come but if you have a peer that needs to participate, please send their information to Candace Rodgers at candace.rodgers@bhddh.ri.gov so they receive the official training application.
- The recovery housing RFP will close on 1/20/2025. To apply, go to Funding Opportunities - Find a Grant Opportunity in Rhode Island.

Wait Lists

MHPRR

For December- 40 clients are currently on the list and three (3) discharges occurred from the wait list.

Between July 2024 and December 2024, there have been anywhere from 40-58 people waiting, with the peak in mid-October:



MHPRR Discharge data July 2024-November 2024

Discharge Month (YYYYMM)	MHPRR Discharges (includes supported housing, group homes, and enhanced MHPRR)
July 2024	8
August 2024	<5
September 24	6
October 2024	5
November 2024	5

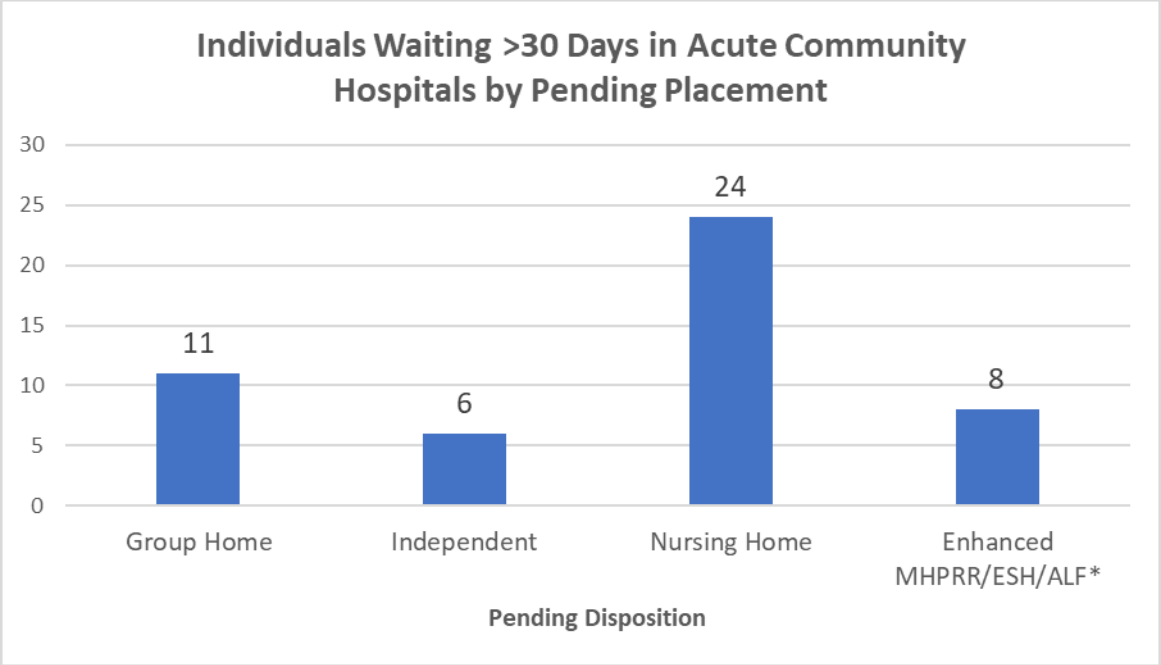
EMHPRR

- 8 clients awaiting a medically intensive E-MHPRR
- 12 clients awaiting a behaviorally intensive E-MHPRR

SUD RESIDENTIAL

There are 51 placement ready males and 16 placement ready females (67 total individuals) waiting for SUD residential.

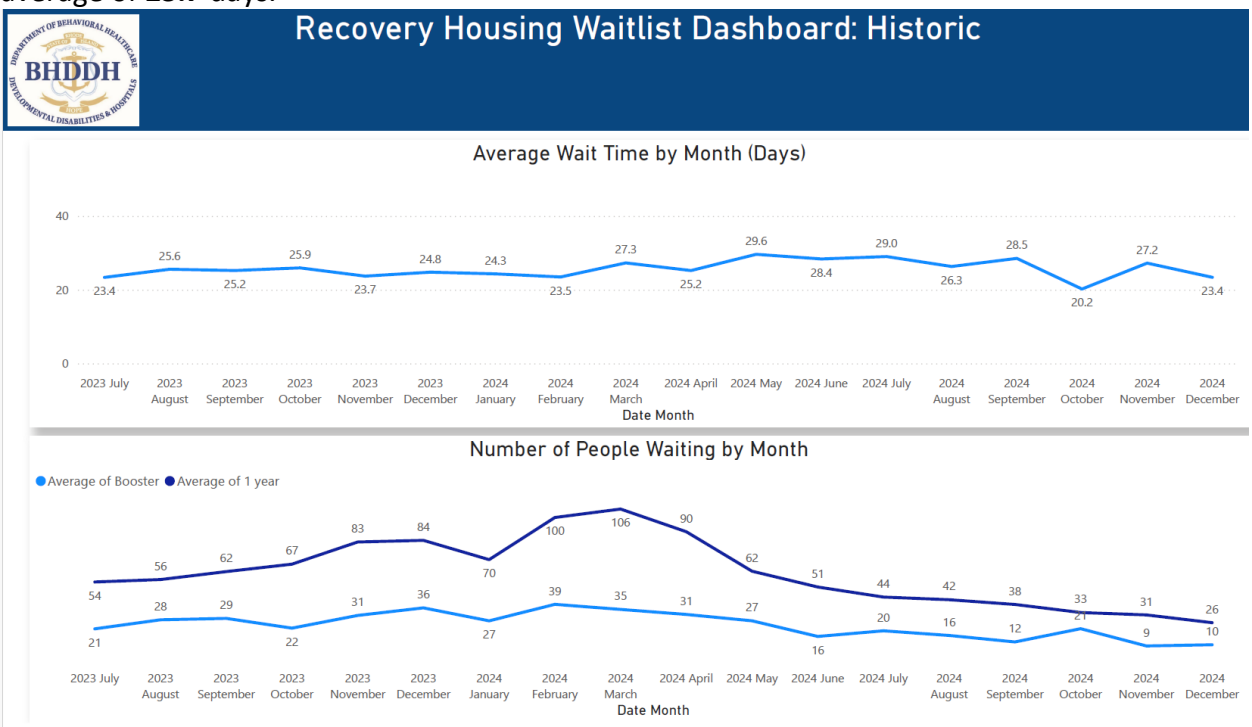
Males on the waitlist had a median wait time of 10 days and a mean wait time of 14 days while females had a median wait time of 17 days and a mean wait time of 18 days.



There are 49 discharge ready people currently waiting for placement waiting more than 30 days
To avoid sharing cells under 5, those with an * are combined categories

Recovery Housing

There are currently **53** individuals on the waitlist and they have been waiting an average of **23.7** days.



EOHHS – Marti Rosenberg

Governor's Overdose Task Force:

- The December Governor's Overdose Task Force's meeting was a review of the community conversation key takeaways and presentation from the Overdose Data Council's strategically refreshed metrics and targets.

- The main takeaways from the community conversation were as follows:
    - Address the concerns of marginalized populations that may be affected by the actions of the federal government administration (LGBTQ+, undocumented, and people who use drugs).
    - Ensure racial equity is embedded across the entire continuum of care, including all Task Force pillars and datasets.
    - Prioritize root causes, such as housing, and invest in innovative, evidence-based programs (e.g., medical respite care, home stabilization, and wound care/"street" medicine).
    - Strengthen coordination across State agencies, especially with the Rhode Island Department of Housing, and across peer organizations, certified community behavioral health clinics (CCBHCs), primary care providers, and emergency departments (EDs) to ensure a holistic approach.
    - Strengthen and address emerging issues such as prevention and treatment of infectious disease, changes in drug supply, and local level responses.
    - The Overdose Data Council reminded the Task Force of the overarching 2030 target to reduce fatal overdoses by 30% returning below the 2018 data.
    - They provided an overview of the refreshed metrics from the four main pillars: Prevention, Harm Reduction, Treatment, and Recovery with an equity measure for each.
    - The specific information and feedback can be viewed on the Prevent Overdose RI website: https://preventoverdoseri.org/presentation-archive/
    - The next Task Force meeting will not take place instead EOHHS, RIDOH, and BHDDH, are finalizing an agenda for a Community Overdose Engagement (CODE) Summit that will be held in lieu of the Task Force on Wednesday, February 12th from 8:30 – 4:30 in person at the Crown Plaza in

Warwick. Registration for this event will be sent out next week – this is a free event with breakfast and lunch included.

- The purpose will be for the state, community, and municipalities to come together to discuss SUD and breaking stigma, learning opportunities on how to use local data to drive action, coalition building and strategic planning, and workforce development.

Opioid Settlement Advisory Committee

- There wasn't a December meeting of the Opioid Settlement Advisory Committee (OSAC). Please see these updates:
- Dr. Brandon Marshall was appointed by Governor McKee as the new chairperson (a non-voting member role) of the Opioid Settlement Advisory Committee. Dr. Marshall will be facilitating the next meeting scheduled for January 15th from 1:00 to 3:00 pm, held in person in Conference Room 2A at the Department of Administration.
- The focus for the next OSAC meeting will be:
    - Review Processes Moving Forward
    - Review proposed topics and timeline for 2025
    - Determine cadence of meetings for 2025
    - Review processes for decision making for new membership

Community Based Intensive Care Program

EOHHS issued a Request for Proposals (RFP) for Community-Based Intensive Care (CBIC). CBIC is an intensive home and community-based service carried out by Community Care Alliance and Tides Family Services. The program supports children and youth with the most complex behavioral health difficulties to ensure they are able to remain safely at home or to transition home from psychiatric hospitalizations or intensive residential programs.

Please see the slides below for more details reporting on the program:

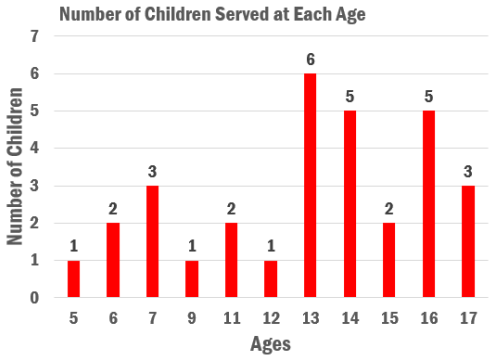
CBIC: The First Ten Months
(03/01/24- 12/31/24)

Total Number of Children Served: 32

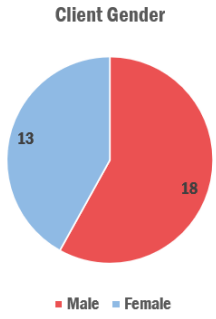
Total Number of Children Discharged: 16

Hospitalization History Prior to CBIC Enrollment:

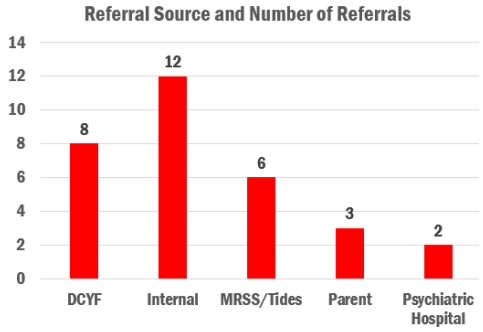
Out of a total of 32 children, 12 (37.5%) had previous inpatient hospitalization, while 9 (28.1%) had previous partial hospitalization.

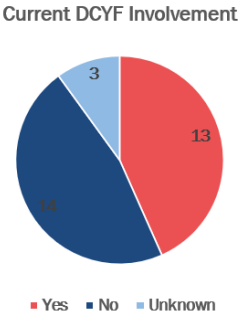


CBIC: The First Ten Months:
(03/01/24- 12/31/24)



CBIC: The First Ten Months
(03/01/24- 12/31/24)





Rhode Island Olmstead Planning

EOHHS has published a new Olmstead Newsletter. If you are interested in receiving the newsletter regularly, please sign up here: https://www.surveymonkey.com/r/QYWYFGW.

Olmstead Advisory Group

The Olmstead Advisory Group met on December 17th, 2024. The key topics of the meeting included:

- Plan Outline and Vision Statement Review
- Updates on Community Listening Session Awards - A review of updates to the planning framework for the Olmstead initiative.
- Review of Proposed Listening Session Questions
- Work Group Updates
- A review of Data Inventory and Asset Mapping Processes
- Public Comment: The public was invited to provide input on the Olmstead Plan's development, ensuring transparency and community engagement.

The next Olmstead Advisory Group meeting is scheduled for Tuesday, January 21st, from 3:00 PM - 5:00 PM, at the Virk's Building, 3 West Road, Cranston, RI 02920. The agenda and Zoom link for virtual attendance will be posted on the Secretary of State's website 48 hours prior to the meeting. To access the Olmstead Advisory Group page, visit: Secretary of State - Olmstead Advisory Group [5d7vp9xab.cc.rs6.net].

Olmstead Advisory Group members are required to attend in person to be counted towards official attendance and to speak. Members can apply for an accommodation to participate virtually by filling out the TeleComm Waiver from the Rhode Island Governor's Commission on Disabilities, available here [5d7vp9xab.cc.rs6.net]. Please note that waivers are not immediately approved and can take a few days or weeks, so we recommend submitting the waiver as early as possible. Members of the public may attend and provide public comment in person or online.

We are working on implementing a more robust plan for accommodating in-person attendees at Advisory Group meetings. However, with the current resources available, we are asking for 7 to 14 days' advance notice for accommodation requests to ensure all needs are met.

Listening Session Update: Funded Opportunity

To inform the Olmstead Planning Process, EOHHS and our Planning Consultant John Snow Inc. (JSI) released a funding opportunity to host community listening sessions. These sessions aim to engage diverse voices, particularly those with lived experience, to inform the development of the RI Olmstead Plan.

We received 14 applications for the upcoming community listening session. A review of this applications identified 12 of the 14 applications as eligible for the award. The awarded partners are:

Bradley Hospital	Refugee Dream Center
Communities for People	Sabater Lab Foundation
Community Care Alliance	The Arc RI
OSCIL	Tides Family Services
Progreso Latino	United Way RI
Red White and Brew	YWCA RI

Community Listening Session have begun and will conclude in the month of January. Information about listening sessions will be posted to the Olmstead Website (**eohhs.ri.gov/Olmstead-Planning [5d7vp9xab.cc.rs6.net]**).

CLS Calendar: 12/20/24 Agency	CLS Meeting Date	TIme	Format
OSCIL	Friday, January 3, 2025	1-3pm	Hybrid
Sabater Lab	Saturday, January 4, 2025	12-2pm	Hybrid
The Arc	Monday, January 6, 2025	11am-1pm	In person
Refugee Dream Center	Monday, January 6, 2025	12-1:30pm	In person
Community Care Alliance	Monday, January 6, 2025	2pm-4pm	In person
The Arc	Monday, January 6, 2025	6pm-7:30pm	In person
Progreso Latino	Tuesday, January 7, 2025	10am-11:30am	In person
YWCA	Tuesday, January 7, 2025	10am-12noon	In person
Bradley Hospital	Tuesday, January 7, 2025	5-6:30pm	In person
OSCIL	Tuesday, January 7, 2025	5-7pm	Hybrid
YWCA	Wednesday, January 8, 2025	10am-12noon	In person
United Way	Monday, January 8, 2024	4:30-6pm	In person
Bradley Hospital	Wednesday, January 8, 2025	5-6:30pm	Online
Communities for People	Wednesday, January 8, 2025	5-7:30pm	Hybrid
The Arc	Wednesday, January 8, 2025	6-7:30pm	Hybrid
Red, White and Brew	Wednesday, January 8, 2025	TBD	Online
Red, White and Brew	Thursday, January 9, 2025	11am-1pm	In person
Refugee Dream Center	Thursday, January 9, 2025	1pm-2:30pm	Online
United Way	Thursday, January 9, 2025	5:30-7pm	Online
Community Care Alliance	Thursday, January 9, 2025	6-8:30pm	Online
Progreso Latino	Tuesday, January 14, 2025	4-5:30pm	In person
Tides	Tuesday, January 7, 2025	4-5:30pm	In person
Tides	Thursday, January 9, 2025	4-5:30pm*	Online

*subject to change

Plan Writing Updates

Based on learning from community engagement efforts and from the four Olmstead Planning Work Groups (Affordable and Accessible Housing, Accessing Community Services, Preventing Abuse/Neglect Stigma and Discrimination, Discharge Planning and Transition) the team has developed the following draft vision and goals, which are being reviewed by the Olmstead Advisory Group.

Vision:

Rhode Island is committed to being a state where people of all abilities are fully included in their chosen community and supported by the resources needed to live a fulfilling life. Rhode Island will be a place where dignity and respect are felt by all, regardless of ability. In Rhode Island, structures will be transformed and information will be readily available so that people with disabilities can make meaningful choices, participate in every aspect of

life, and freely pursue their goals and aspirations--without judgment, stigma, and/or discrimination.

Developing Goals:

- **Goal 1:** Maximizing Interventions That Address the Root Causes and Other Drivers of Segregation and Prevent Conditions That May Result in Disability
- **Goal 2:** Expand Opportunities for Community Integration and Independent Living
- **Goal 3:** Improve network vitality and strengthen network connections to ensure access to comprehensive, coordinated support systems
- **Goal 4:** Foster Equitable Opportunities and Inclusive Environments for Employment and Education
- **Goal 5:** Strengthen Community Capitol, Engagement, Participation and Connection
- **Goal 6:** Ensure adequate governance and resource allocation are maintained to collect data, evaluate efforts, monitor performance, and adapt strategies to fully implement plans and consent decrees.

Strategies & Recommendations

Proposed Strategies and Recommendations are being reviewed and refined. There are over **60 Recommendations** proposed by our work groups and identified through Key Informant Interviews and Community Forums. The Olmstead Advisory Group and state partners from over 20 organizations units are supporting us in identifying existing assets that can be built off to support recommendations and existing baseline measures, where available.

Olmstead Website

We are excited to share the Rhode Island Olmstead website! This platform is designed to keep you updated on our ongoing efforts to create a more inclusive and accessible community for individuals with disabilities. On the website, you will find:

- Olmstead Plan Updates: Stay informed on the progress of the Rhode Island Olmstead Plan and upcoming community initiatives.
- Survey Participation: Share your voice by taking part in the Olmstead Prioritization Survey and helping to shape future priorities.

Visit us at **eohhs.ri.gov/Olmstead-Planning [5d7vp9xab.cc.rs6.net]** and get involved in making Rhode Island a more inclusive place for all

RIDOH – Kristine Campagna

Violence and Injury Prevention Program (VIPP)

The Cross Campus Learning Collaborative for Sexual Violence Prevention, a program of the Rape Prevention Education program within VIPP, is hosting a joint meeting with gender-based violence and suicide prevention professionals in higher education on Jan. 16th. A presentation on RI Young Adult Survey data on "restrictive masculinity norms" and their connections to health outcomes will be shared and spark discussion and networking among the group. This data was collected for the first time in the summer of 2024 via BHDDH funding and captures health and wellness data from young adults (ages 18-25) in Rhode Island.

**

Parent Coach RI, a resource for parents to learn tips and tricks for helping to improve their child's mental health while also taking care of themselves, has been transitioned to the PreventSuicideRI.org website. Formerly, parents could sign up to receive a daily text for 30 days. For sustainability of the resource, it has been transitioned to an email subscription, in which parents can receive five emails on a weekly basis with the same content provided by the texting feature.

**

The Falls Prevention Program is hosting a Tai Ji Moving for Better Balance instructor training on January 8th and 9th. The opportunity is geared towards college students who are interested in health professions to help them learn about evidence-based Fall Prevention Programming and increase capacity for implementing these programs.

Drug Overdose Prevention Program

"Small Amount" Video Campaign Receives VIDDY Award

Rhode Island's 2024 "Get Ready with Me" video series from *Small Amount/Fentanyl Risks* campaign received a Gold from the Viddy Awards, which is "one of the oldest, largest, and most respected awards programs in the video industry. With more 50,000 entries worldwide from over 100 countries, Viddy attracts the most prestigious businesses, production companies, agencies, broadcasters, and individual creatives in the video universe." The videos were filmed in a casual, relatable setting, where a young person

shares safety tips—like using fentanyl test strips, carrying naloxone, and never using drugs alone—while preparing for a night out.

The videos were delivered in a friendly, non-judgmental tone, produced in English, Spanish, and Cape Verdean Creole, and distributed across TikTok, Snapchat, and Instagram. They generated **nearly 10 million impressions and drove over 27,000 new web users** to the Prevent Overdose RI campaign landing page. Local marketing partner, Reach Consulting, shared this positive news about the "Get Ready with Me" videos here on Facebook.

**

Save the Date: 2025 Statewide Community Overdose Engagement Summit

In efforts to bring together community members and leaders to address Rhode Island's overdose crisis, Governor Dan McKee's Overdose Task Force invites you to participate in the **2025 Statewide Community Overdose Engagement (CODE) Summit** on **February 12, 2025**, from **8:30 a.m. to 4 p.m.** at the Crowne Plaza Hotel in Warwick, Rhode Island.

The goals of the 2025 CODE Summit are to:

- Learn and interact with fellow Rhode Islanders who are invested in ending the overdose crisis;
- Share local resources for overdose prevention, harm reduction/rescue, treatment, and recovery; and
- Engage municipalities in the development and planning of localized overdose response plans.

Please note that the 2025 CODE Summit will occur in place of the February 2025 Overdose Task Force meeting.

**

Governor's Overdose Task Force Newsletter for December

Read the latest edition of the Governor's Overdose Task Force Newsletter, featuring meeting highlights, a report from the November meeting's community conversation, a presentation from the Rhode Island Overdose Data Council, a "save the date" of Feb. 12 for the 2025 Statewide CODE Summit, and other news.

Tobacco Control Program (RITCP)

Menthol-Related Health Equity Short-Term Project Application

The Rhode Island Department of Health Tobacco Control Program (RITCP) is offering three (3) short-term projects of up to $3,000 each to Rhode Island community/faith-based organizations. The organization(s) must be located or serving in Providence and

have demonstrated proven engagement with communities affected by menthol-related health disparities (e.g., African-Immigrants and/or African Americans). Organizations must serve the special populations that reside or work in the Providence Metro area, and must have 501c3 status (e.g., nonprofit, faith-based, public libraries, youth development organizations, etc.). The organization(s) must aim to reduce access to menthol and other flavored tobacco/nicotine products in communities. Preference will be given to applications that document a capacity to implement tobacco/nicotine-free policies and educate on the harms of tobacco/nicotine use and tobacco industry practices through policy, environmental, system change strategies, data collection, improved enforcement, and public education. All eligible applicants MUST be registered in Ocean State Procures (OSP) with an up-to-date W-9. Information about OSP can be found here: Ocean State Procures (OSP) | Rhode Island Division of Purchases (https://ridop.ri.gov/ocean-state-procures-osp). To register with OSP click here: Osp Vendor Registration | Rhode Island Division of Purchases (https://ridop.ri.gov/ocean-state-procures-osp/osp-vendor-registration). **The application deadline for this funding opportunity has been extended. Applications are now due by January 24, 2025.**

DCYF – Chris Strnad

DCYF Strategic Plan:
DCYF has released a 26-page strategic plan that is available on the DCYF website: https://dcyf.ri.gov/sites/g/files/xkgbur416/files/2024-12/RI%20DCYF%20Strategic%20Plan_Final%20PDF.pdf.

This strategic plan is the result of a comprehensive, 10-month Listening and Learning initiative that engaged youth families, staff, and community partners throughout the state. The plan is focused on four core pillars – Prevention, Accountability, Collaboration and Engagement (PACE) – to ensure that children and families are helped early and get the supports they need so that children can thrive with families and avoid out-of-home care.

COA Accreditation for DCYF:
The Department had a full Site Review from the Council on Accreditation (COA) from November 18-20. The purpose of the Site Review was to assess the agency's implementation of the standards and share feedback with COA. The Site Review included a case record review; personnel record review; and formal interviews with staff, leadership, families, and community partners; informal interviews with additional staff; and observations of two of the Department's child welfare facilities (the Providence and Bristol offices). The Department also submitted hundreds of additional artifacts (e.g., meeting notes, recent outcomes data, training curriculum) two weeks prior to the visit to support demonstration of implementation.

Following the site review, COA provided a “pre-commission“ report to DCYF on December 11. The feedback received was overwhelmingly positive; out of more than 400 items scored, the site review team identified only three areas where additional evidence is recommended: (1) establishing performance reviews for direct casework staff; (2) updating personnel record keeping; and (3) finalizing an updated policy for transportation of children that has been under negotiation with the union. No recommended improvements were deemed necessary related to child welfare or children’s behavioral health practice or management.

By January 23, 2025, the Department must submit a response to this pre-commission report that details how we have addressed the feedback received. The Accreditation Commission then reviews this follow-up information and makes the final accreditation decision. The Department is hopeful that it will receive notification of accreditation in February 2025. This will be the first time the Department has achieved national human services accreditation.

Rhode Island Department of Human Services (DHS) – Donna Rook

Housing Stability Pilot – The HSP provides nonrecurrent, short term financial benefits, designed to assist eligible families resolve a specific housing crisis and maintain housing stability. The HSP is funded by the Federal TANF block grant and is authorized under the grant’s Non-Recurrent Short-Term (NRST) Benefit feature. Eligible families must be experiencing a specific housing crisis that can be resolved with short term financial assistance. Families can either be currently housed and request assistance to prevent homelessness or can be currently homeless and request assistance to move them directly out of homelessness into permanent housing.

Agency Storytelling – DHS is continuing a focused effort to better communicate the good work of the staff and those we serve, as well as those we partner with to ensure we help those in need. DHS is in the process of establishing awareness on this approach, while developing a way to capture stories, highlights, positive customer feedback, engagement, and staff collaboration. We look forward to telling these stories both internally and externally via social media, newsletters, media relations, etc…

STATE OF RHODE ISLAND

Governor's Council on Behavioral Health
6 Harrington Road
Cranston, RI 02920
Tel: (401) 462-1910
Email: Natasha.Andrews@bhddh.ri.gov

Governor's Council on Behavioral Health
Thursday, June 12, 2025; 9:00 – 10:30 a.m.
CODAC Behavioral Healthcare
45 Royal Little Drive ~ Community Room Providence, RI 02904

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

Welcome – Chair Warner/Director Leclerc (5 minutes)
Motion for Approval and Vote on April Meeting Minutes

Presentations and Discussion

- FY2024-FY2025 Block Grant Needs Assessment – Michelle Stage, M.S.
  Orianna D. Carvalho, Ph.D. (40 minutes)
- Create BH Workforce ADHOC Committee-Vote – Chair Larry Warner (5 minutes)

Proposed Topics – Chair Larry Warner (10 minutes)

Committee Updates (10 minutes)
- Olmstead – Laurie-Marie Pisciotta
- Prevention – Daniel Fitzgerald
- Suicide Prevention – Kerrie Constant, Chair Larry Warner

Department Updates (10 minutes)
- BHDDH – Thomas Martin
- RIDOH – Kristine Campagna
- OHHS – Marti Rosenberg
- DCYF – Chris Strnad
- OHA – Meghan Connelly
- DHS – Donna Rook

Closing Comments/Announcements (10 minutes)

Next Meeting: Thursday, July 17, 2025 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.

STATE OF RHODE ISLAND

Governor's Council on Behavioral Health
6 Harrington Road
Cranston, RI 02920
Tel: (401) 462-1910
Email: Natasha.Andrews@bhddh.ri.gov

Governor's Council on Behavioral Health
Thursday, July 17, 2025; 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

Welcome – Chair Warner/Director Leclerc (5 minutes)
Motion for Approval and Vote on June Meeting Minutes

Presentations and Discussion

- Legislative Update/2025 – Karyn Lowe, Office of the Governor (10 minutes)
- FY26 Block Grant Application – Stephanie Harrington, BHDDH (40 minutes)

Proposed Topics – Chair Larry Warner (10 minutes)

Committee Updates (10 minutes)
- Olmstead – Laurie-Marie Pisciotta
- Prevention – Daniel Fitzgerald
- Suicide Prevention – Kerrie Constant, Chair Larry Warner

Department Updates (5 minutes)
- BHDDH – Thomas Martin
- RIDOH – Kristine Campagna
- OHHS – Marti Rosenberg
- DCYF – Chris Strnad
- OHA – Meghan Connelly
- DHS – Donna Rook

Closing Comments/Announcements (10 minutes)

Next Meeting: Thursday, September 18, 2025 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 Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Dennis Bailer	Persons in Recovery from or providing treatment for or advocating for SUD services			dbailer@weberrenew.org
Tara Boulais	Parents of children with SED			tarab0778@icloud.com
Linda Bryan	Parents of children with SED			lindadee76@icloud.com
Richard Charest	State Employees			richard.r.charest@ohhs.ri.gov
Maria Cimini	State Employees			Maria.E.Cimini@oha.ri.gov
Megan Clingham	State Employees			megan.clingham@doa.ri.gov
Ashley Deckert	State Employees			ashley.deckert@dcyf.ri.gov
Daniel Fitzgerald	Advocates/representatives who are not state employees or providers			daniel.fitzgerald@lung.org
Christine Gadbois	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			christinegadbois75@gmail.com
Ines Garcia	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			igarcia@EBCAP.org
Lindsay Garcia	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			lindsay_garcia@brown.edu
Michael Hogan	State Employees			michael.hogan@risp.gov
Linda Hurley	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			lhurley@codacinc.org
Angelica Infante -Green	State Employees			angelica.infantegreen@ride.ri.gov

Ian Lacombe	Advocates/representatives who are not state employees or providers			ianlacombe@yahoo.com
Jerome Larkin	State Employees			jerome.larkin@health.ri.gov
Richard Leclerc	State Employees			rich.leclerc@bhddh.ri.gov
Margaret McDuff	Parents of children with SED			mhmcduff@familyserviceri.org
James McNulty	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			jmcnultyri@gmail.com
Katelyn Medeiros	State Employees			Katelyn.Medeiros@doa.ri.gov
Kimberly Merolla -Brito	State Employees			kimberly.brito@dhs.ri.gov
Joseph Murphy	State Employees			joseph.murphy@ors.ri.gov
Peter Neronha	State Employees			
George O'Toole	Persons in Recovery from or providing treatment for or advocating for SUD services			Gotoole@EBCAP.org
Laurie Pisciotta	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			laurie.pisciotta@mhari.org
Wayne Salisbury	State Employees			wayne.salisbury@doc.ri.gov
Janet Spinelli	Advocates/representatives who are not state employees or providers			janetspin@aol.com
John Tassoni	Advocates/representatives who are not state employees or providers			john@jtsentinelgroup.com
Lisa Tomasso	Advocates/representatives who are not state employees or providers			Lisat@hari.org
Michael Tondra	State Employees			michael.tondra@housing.ri.gov
Larry Warner	Advocates/representatives who are not state employees or providers			larry.warner@unitedwayri.org

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	4	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	2	
3. Parents of children with SED	3	
4. Vacancies (individuals and family members)		
5. Total individuals in recovery, family members, and parents of children with SED	**9**	**29.03%**
6. State Employees	14	
7. Providers	0	
8. Vacancies (state employees and providers)		
9. Total State Employees & Providers	**14**	**45.16%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	2	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	6	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)		
15. Total non-required but encouraged members	**8**	**25.81%**
16. Total membership (all members of the council)	**31**	

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Footnotes:

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

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, that 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 the federal government.

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/bhddh-grant-information

https://bhddh.ri.gov/substance-useaddiction/block-grant-information

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/bhddh-grant-information

https://bhddh.ri.gov/substance-useaddiction/block-grant-information

c) Other (e.g. public service announcements, print media) ( ) Yes (●) No

d) Please indicate areas of technical assistance needs related to this section.
N/A

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Footnotes:

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:
Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

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 SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG 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 SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (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. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the **HIV.gov website.**

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. 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 SUPTRS BG 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.

2. 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 SUPTRS BG 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.

3. 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 SUPTRS BG 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 use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
No Data Available					
Totals:		$0.00		0	

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Footnotes:

Rhode Island does not plan to use funding for syringe services.