

Rhode Island

UNIFORM APPLICATION

FY 2016/2017 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

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

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 11/23/2015 2.18.44 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State SAPT DUNS Number

Number 111415381

Expiration Date

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

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

Organizational Unit Division of Behavioral Health

Mailing Address 14 Harrington Road

City Cranston

Zip Code 02920

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

First Name Maria

Last Name Montanaro

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

Mailing Address 14 Harrington Road

City Cranston

Zip Code 02920

Telephone 401-462-2339

Fax 401-462-3204

Email Address maria.montanaro@bhddh.ri.gov

State CMHS DUNS Number

Number 111415381

Expiration Date 5/11/2013

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

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

Organizational Unit Division of Behavioral Health

Mailing Address 14 Harrington Road

City Cranston

Zip Code 02920

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

First Name Maria

Last Name Montanaro

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

Mailing Address 14 Harrington Road

City Cranston

Zip Code 02920

Telephone 401-462-2339

Fax 401-462-3204

Email Address maria.montanaro@bhddh.ri.gov

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

From

To

IV. Date Submitted

Submission Date 9/1/2015 2:19:16 PM

Revision Date 11/17/2015 11:56:08 AM

V. Contact Person Responsible for Application Submission

First Name Michelle

Last Name Brophy

Telephone 401-462-2770

Fax 401-462-3204

Email Address michelle.brophy@bhddh.ri.gov

Footnotes:



An error occurred

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<DATE>

Deepa Avula, Acting Director
Division of Grants Management, OPS
SAMHSA
1 Choke Cherry Road
Room 7-1091
Rockville, MD 20857

Dear Ms. Avula:

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

Sincerely,

Gina Raimondo
Governor

State Information

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

Fiscal Year 2016

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
 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 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

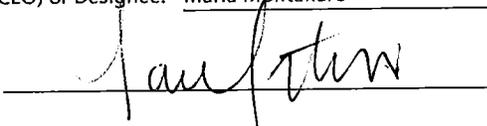
The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Maria Montanaro

Signature of CEO or Designee¹: 

Title: Director

Date Signed: 2/20/15

mm/dd/yyyy



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<DATE>

Deepa Avula, Acting Director
Division of Grants Management, OPS
SAMHSA
1 Choke Cherry Road
Room 7-1091
Rockville, MD 20857

Dear Ms. Avula:

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

Sincerely,

Gina Raimondo
Governor

State Information

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

Fiscal Year 2016

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
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 as required by
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 and
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Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
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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.
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2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

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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.

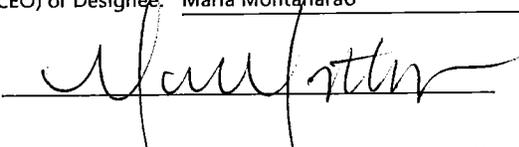
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The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental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

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: Maria Montanarao

Signature of CEO or Designee¹: 

Title: Director

Date Signed: 8/20/15

mm/dd/yyyy

State Information

Disclosure of Lobbying Activities

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

[Standard Form LLL \(click here\)](#)

Name	<input type="text" value="Maria Montanaro"/>
Title	<input type="text" value="Director"/>
Organization	<input type="text" value="Rhode Island Department of Behavioral Healthcare, Develo"/>

Signature: _____ Date: _____

Footnotes:

Planning Steps

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

Narrative Question:

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

Footnotes:

Step 1: Assess the strengths and needs of the service system to address the specific populations. Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Overview of the State's Behavioral Health System: Introduction

Rhode Island has undertaken a major reinvention of its healthcare, including behavioral healthcare, system. The process takes a lifespan approach towards behavioral healthcare, and identifies needs both in services to different populations and in service delivery systems.

Rhode Island's Executive Office of Health and Human Services, which encompasses the Division of Medicaid, Department of Children, Youth and Family, the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, the Department of Human Services (Division of Elderly Affairs, Division of Veterans Affairs) and the Department of Health made a commitment to strengthen mental health and addiction services beginning with a comprehensive assessment of its behavioral healthcare system. The study was solicited by the Executive Office of Health and Human Services and an inter-agency team which included BHDDH, the State's Mental Health and State Substance Authority and co-Single State Agency (see explanation under EOHHS). The study, conducted by *Truven Health Analytics*, revealed that behavioral health disorders are the largest single source of disease and cost in Rhode Island and the prevalence of behavioral health conditions is higher in Rhode Island than in other New England states. The study further revealed that the vast majority of Rhode Islanders affected by Mental Health and Substance Use Disorders do not use specialized behavioral health services. However, they do access other sectors of the health care system—as well as other systems such as social services, housing and education. A fundamental challenge in responding effectively to all potential clients is in coordinating a broad range of services and supports.

Over the past two years there have been substantial changes to the function of the State's Medicaid fiscal system, including, consolidating the Medicaid fiscal function, shifting to a managed care model and implementing the Affordable Care Act. The State of Rhode Island became an expansion state which means that individuals who traditionally did not have access to medical insurance, typically unaccompanied adults, are now eligible for health insurance. The State chose to provide individuals in the expansion population with a benefits package similar to those available to individuals eligible through traditional Medicaid. Currently, for adults who are part of the expansion population, all Mental Health and Substance Use Disorder treatment is covered through managed care; whereas, the traditional Medicaid population receive their behavioral health care services through a 'carve out' service. These 'carve out' services are

provided through fee for service contracts with RI's licensed behavioral healthcare organizations. BHDDH is still responsible for the overall policy, planning and oversight of services for youth and adults with substance use disorders and adults with mental health disorders and works closely with the Medicaid office to ensure compliance and monitoring of the managed care organization (MCO) contracts.

In order to address the findings of the Truven study, Rhode Island, under the leadership of EOHHS, is participating in two major initiatives with the goal of transforming our health and behavioral healthcare system with the triple aim of **improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.** The State is moving towards a public health model that integrates physical and behavioral health care through the State Innovations Model (SIM) grant and Reinventing Medicaid legislation. These two initiatives are bringing together experts from our state departments, the community and consumer and advocacy groups to ensure there is a holistic approach and inclusive planning process.

These changes are important to the Block Grant planners for several reasons:

- 1) The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) has requested that SAMHSA recognize a "co-SSA" between BHDDH and the Executive Office of Health and Human Services (EOHHS), as EOHHS now administers the entire Medicaid budget. This will ensure that the state reaches its Maintenance of Effort requirement. BHDDH will continue to be responsible for all policy, monitoring and planning efforts as the co-SSA.
- 2) Many of the individuals prioritized through the block grant now have access to coverage. Therefore, over the next year, it will be important to ensure that block grant funds are not providing services that can be covered by Medicaid, that we maximize individuals receiving enrollment assistance and that any remaining funds address system gaps.
- 3) Through the SIM grant and Reinventing Medicaid project, the state departments are collaborating in an unprecedented manner to address major barriers to services that cross departments. This will influence our planning needs and gap identification as we begin to systematically address areas that have not been areas of focus such as housing retention supports and recovery services.

Executive Office of Health and Human Services

In June of 2007, EOHHS was created to serve as the principal agency of the executive branch of state government to coordinate the human-services departments. These departments include the Departments of Children, Youth and Families; Health; Human Services; and Behavioral Healthcare, Developmental Disabilities and Hospitals (formerly Mental Health, Retardation and Hospitals). The intent of OHHS is to:

Lead the state's four health and human services departments in order to:

- (1) Improve the economy, efficiency, coordination, and quality of health and human services policy and planning, budgeting and financing.
- (2) Design strategies and implement best practices that foster service access, consumer safety and positive outcomes.
- (3) Maximize and leverage funds from all available public and private sources, including federal financial participation, grants and awards.
- (4) Increase public confidence by conducting independent reviews of health and human services issues in order to promote accountability and coordination across departments.
- (5) Ensure that state health and human services policies and programs are responsive to changing consumer needs and to the network of community providers that deliver assistive services and supports on their behalf.

Medicaid funded Services and Managed Care Organizations:

In 2014 the fiscal authority for managing the State share of Medicaid-funded behavioral healthcare services passed from BHDDH to the Executive Office of Health and Human Services, specifically the Medicaid office. BHDDH is under the authority of the Secretary of EOHHS, therefore, the Governor has established a “co-SSA” between BHDDH and EOHHS. BHDDH remains the authority for policy, monitoring and planning any behavioral healthcare issues and Medicaid expenditures that flow through EOHHS are allowed to count towards our Maintenance of Effort. In addition, all behavioral healthcare services for the Medicaid Expansion population are managed by one of two MCOs, Neighborhood Health Plan of Rhode Island and United Healthcare, Optum. BHDDH staff meets monthly with the Medicaid Division, the MCOs and the trade association for behavioral health organizations, to discuss quality and service delivery.

BHDDH retains licensing and regulatory authority and is responsible to ensure regulatory compliance and quality assurance for all agencies and programs licensed by the Department. The Department also work in tandem with the Medicaid office to ensure all behavioral healthcare programs residing under the managed care contracts are meeting the Department’s quality standards.

Department of Children, Youth and Families

The Rhode Island Department of Children, Youth and Families (DCYF), is the unified state agency with combined responsibility for child welfare, children’s behavioral health and juvenile corrections. The Department is statutorily designated (RIGL 42-72-5) as the “*principal agency of the state to mobilize the human, physical, and financial resources available to plan, develop, and evaluate a comprehensive and integrated statewide program of services designed to ensure the opportunity for children to reach their full potential. Such services shall include prevention, early intervention, outreach, placement, care and treatment, and aftercare programs. The Department shall also serve as an advocate for the needs of children.*”

DCYF refined its vision and mission to reflect DCYF's system transformation built on communication and partnerships, as follows:

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

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

Through multiple programs extending through a range of community-based care to residential treatment, the DCYF provides child protection, child welfare, children's behavioral health and education, preventive services to children at risk of abuse/neglect, support services for children and families in need, and services for youth requiring community supervision or incarceration due to delinquency. This combined responsibility and service structure positions DCYF quite well for working in concert with other state departments, community-based agencies and family representatives to continuously develop and improve strategies that address fundamental needs of children and families. This combined responsibility and service structure offers a tremendous opportunity for DCYF, working in concert with BHDDH and other state departments, community based agencies and family representatives, to develop a statewide integrated system of care approach to meet the behavioral health needs of children, youth and their families in Rhode Island.

The State of Rhode Island is the smallest in the nation with a population of just over 1 million. The DCYF is a State administered child welfare system with a centralized child protection operation -- one of the strongest in the country with response times for investigations ranging from as immediate as 10 minutes to within 24 hours, but all of the investigations that are conducted are initiated within 24 hours. There are four regionalized offices to promote a more community-based service system within the state. Each DCYF Region has a Regional Director and family service units (FSU) with social caseworkers who are responsible for case management and visitation schedules for families with cases open to the Department. Children and families are assigned to family service caseworkers on a regional basis. Programs and Direct Services are delivered through three service divisions:

- Child Welfare which includes Child Protective Services (including Intake) and Family Services;
- Juvenile Probation/Parole and Juvenile Corrections (Rhode Island Training School); and
- Children's Community Services and Behavioral Health

Child Welfare

In FY 2014, a total of 7,456 investigations were completed by Child Protective Services (CPS) of which 2,346 were indicated. After several years of declining caseload numbers, DCYF has seen an increase in the volume of families requiring DCYF intervention. In the table to the right, data shows that as of December 31 for the last four years, a reversal in the steady decline in

active caseloads and in the number of children in substitute care that DCYF had been seeing in previous years.

As of December 31	2011	2012	2013	2014
At the same time, the number of children able to be maintained in their own homes under DCYF supervision was greater than the number of children placed in foster care in each year, except for FY14. These trend lines represent a general trend that accompanies the DCYF's continued focus on maintaining children safely in their homes with supportive home and community-based services. Much of this emphasis was focused on the front-end of DCYF's service system – helping child protection investigators to work more diligently with families and community providers to avert families from being opened to the DCYF wherever possible and appropriate.				
# Active Caseloads	6,828	6,795	6,990	7077
# Children in Substitute Care	1,988	1,947	2,013	2164
# Children at Home	2,141	2,208	2,456	2371

Supported by federal funding, community liaisons are co-located in DCYF, to assist families in connecting to community resources. For example, a nurse liaison from an Early Intervention program, is working with DCYF's child protective services to implement a regularized referral process for children under the age of three to an Early Intervention program or other appropriate early child development and family support program.

Family Service Units provide services to children, youth and families who are in out of home care. Research has shown that children in placement have higher rates of use of psychotropic medication than children at home. DCYF is responsible for all out of home care for children and youth except for psychiatric hospitalization and other medical treatment that is managed by EOHHS/Medicaid. DCYF monitors psychotropic medications, behavioral health services and behavioral health diagnosis of children and youth in Foster Care (Federal definition) through data provided by the State's Managed Medicaid, Neighborhood Health Plan. When children and youth are removed from their home and placed into DCYF care and custody, Neighborhood Health Plan becomes their health plan provider.

DCYF and Neighborhood Health Plan of RI developed a system to improve the informed consent process that utilizes medical expertise, monitoring the use of psychotropic medication, implementing a response system to ensure appropriate use of psychotropic medication, and implementing evidence-based, trauma-informed assessment practices to ensure appropriate intervention and implementation. This new system has been designed to collect specific data on the use of psychotropic medication for DCYF population in child welfare, behavioral health and juvenile justice system. This includes information on the most frequently prescribed psychotropic medications, the use of psychotropic medication in relationship to behavioral health services, diagnoses and the hospitalization and re-hospitalization of children and youth.

Data collected from Neighborhood Health Plan is being analyzed for CY 2013 and 2014. Preliminary data indicates that for average of over 2360 children per quarter in out of home placement about 21% were on at least one psychotropic medication and around 33% had at least one Behavioral Health diagnosis. Over 60% of children and youth were on ADHD medication. The next most prescribed medications were antidepressants and antipsychotics. It is important

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to note that the data presented on psychotropic medications, behavioral health services and diagnosis, reflects only those that Neighborhood Health Plan pays for and is tracked within their data system. There may be an undercount of behavioral health services or diagnoses if the health insurer, NHP, is not the payer or if the child/youth did not receive behavioral health services during the reporting period timeframe.

The data shows there were some positive trends in the reduction of psychotropic medications over the time period:

- Reduction in the percentage of children/youth on 1+ psychotropic medication from 21.9% in 2013 Quarter 1 to 19.5% in 2014 Quarter 3
- Reduction in the percentage of children/youth on 2+ psychotropic medications concurrently from 8.4% in 2013 Quarter 1 to 5.9% in 2014 Quarter 3

An area where the trend presented challenges was seen in a nonlinear trend in the percentage of children and youth on a psychotropic medication and a behavioral health hospitalization:

- 2013 Quarter 1, 6.8% of youth on a psychotropic medication had a behavioral health related hospitalization which decreased in 2014 Quarter 1 to 5.9% which then increased in 2014 Quarter 3 to 8.6%

Juvenile Corrections

The Division of Juvenile Corrections is comprised of the Rhode Island Training School for Youth (Training School) and Probation and Parole Services. In 2009, DCYF, in conjunction with the RI legislature, the Department of Administration (DOA) and the RI Department of Education (RIDE), opened a new, state-of-the-art facility, the Thomas C. Slater Training School for Youth, which functions as RI's only juvenile correctional facility. This facility houses both male and female offenders through age 18. The mission of the Training School is to provide a structured environment to enable youth to progress toward successful reintegration within the community.

DCYF has been working to reduce reliance on institutional placement of juvenile offenders as studies show this population fares better in evidence-based and evidence-informed programming delivered at home or in the community. As a result of the various initiatives and oversight, a steady decline in the average daily population has occurred from 190 youth in 2007 to 93 youth in 2014 which is more than a 48% decrease. The average length of stay for males is 52 days and for females is 21.7 days according to the Juvenile Detention Alternatives Initiative Data Presentation March 4, 2015. Female juvenile offenders represented 11% of the average daily population in 2014. In 2012 females were only 9%.

For youth in Training School there is a range of interventions customized to their needs. The Training School maintains a system that combines independently validated risk assessments (GAIN) and a mental health screening instrument, Massachusetts Youth Screening Instrument Version 2 (MAYSI-2) with the professional judgment of multidisciplinary teams to assess individual needs and to identify risk factors that must be addressed. In July, the SAVRY (Structured Assessment of Violence Risk in Youth) will be used to assess risk and needs.

These assessments are used to inform family court and to guide a youth's movement within the juvenile justice continuum of care, which also includes Probation, the Youth Assessment Center, and the Youth Development Center, the Female Program, Temporary Community Placement and ultimately transition to the community. There are Administrative Review Meetings to support the youth's transition back to the community. Educational and Vocational programming are also a major component at the RITS and include a Barbering Apprentice Program, art program through AS220 and a very successful Culinary Program that has resulted in the Harvest Kitchen.

The Training School addresses both the mental health and substance use treatment issues of their residents as well as rehabilitative and vocational needs. According to the 2015 Rhode Island Kids Count, in 2013, 155 youth (139 males and 16 females) were under the care of the training School's psychiatrist. Psychiatric medications were prescribed to 137. Services through a contract with Lifespan Corporation provided outpatient or residential substance abuse services to 188 residents at the Training School.

A comprehensive transitional planning initiative for all youth who are sentenced to serve time at the Training School was implemented in the spring of 2014. Formal and informal meetings of probation and Training School staff, with youth and family, addressed the high risk time period for re-entry. The youth is transitioned from the Training School to a probation transition unit where they receive intensive supervision and treatment as established in their discharge plan. This approach focuses on what research has shown to be the highest risk period for youth to produce better results.

Over the past three years (2012 to 2015) the Home Confinement/Electronic Monitoring Program (HC/EM) has served over 500 high risk youth. HC/EM was the result of collaborative efforts of the Family Court, DCYF, Public Defenders Office, the Attorney General and the General Assembly as legislation was passed that created this program. In calendar year 2014, 242 youth were served by this program. The success rate for youth remaining in their community through use of this program is over 82%.

Probation and Parole

The number of youth on probation has been decreasing over the past 8 years. During FY 2007 there were 2,390 youth on probation with an average daily caseload size of 1,371. In 2009 the Juvenile Detention Alternative Initiative (JDAI) was brought to RI by the Casey Foundation. This resulted in stakeholders, including representatives of the Family Court, the Attorney General, the Public Defender, the Child Advocate, law enforcement and social service agencies serving the juvenile justice probation working together on system level reform.

From 2009 to 2014 there has been a 55% reduction in the number of youth on probation. In FY 2014 the number of youth on probation decreased to an average daily caseload of 530. An array of services are now available to help youth including court ordered treatment such as MST, Preserving Families Network, Youth Transition Centers or temporary placement in a residential setting.

Youth Transition Centers (YTC): YTC is a public/private collaboration between a community services organization and Juvenile Probation/Parole for high risk youth on probation or leaving

the Training School. Youth receive services in the community with an emphasis on strengthening families by integrating outreach and tracking services from the community services program. YTC provides both prevention and rehabilitative services to around 85 youth per year.

The Division of Community Services and Behavioral Health (CSBH)

Community Services and Behavioral Health focuses on ensuring that effective services are provided to support children in the least restrictive environment possible to support child safety, permanency and wellbeing, and overall family functioning. CSBH assists children and families involved with DCYF to access an array of behavioral health services based on assessments and needs of the child. CSBH provides oversight for DCYF funded services and programs that are administered by the various community organizations including the four regional Family Care Community Partnerships (FCCPs), the two Family Care Networks (FCNs) and other community providers. CSBH staff work with community agencies through contracts and collaboratives to provide a variety of prevention activities, workshops, trainings and services for the community.

CSBH provides a *Guide to Community-Based Services* which contains a listing of DCYF funded services. This includes Multi-systemic therapy (MST), Youth Diversionary Programs and Intensive home-based programs, child and family behavioral health services that are accessed through health insurance, services that are available through Medicaid funding such as Comprehensive Evaluation Diagnosis Assessment Referral Re-evaluation (CEDARR), Respite and Home-Based Therapeutic Services (HBTS), and other community agencies that provide mental health services and supports.

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

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

Chafee Foster Care Independence Program

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

The Consolidated Youth Services (CYS)

DCYF designed the CYS Program to ensure older youth in the care and custody of the DCYF, as well as youth aging out and former foster youth have the tools, resources and opportunities that will increase the likelihood they will successfully transition from DCYF care. Services are available to all youth ages 16-21 who are in foster care or who were in foster care after their 16th birthday, including youth who left foster care for kinship guardianship or adoption after their 16th birthday. The CYS program either directly or through collaboration with other agencies, provides financial support, housing, counseling, employment, mental/physical/sexual health, food assistance, educational and other appropriate services to former foster care recipients between the ages of 18-21. These services complement a youth's own efforts to achieve self-sufficiency and assure that program participants recognize and accept personal responsibility for preparing to transition into adulthood.

The goal of the program is to increase the likeliness that youth will successfully transition from DCYF care by providing the necessary tools, resources and opportunities. Support services were provided quarterly to approximately 1677 older youth in FY 2014. The CYS Program includes the following direct and/or indirect service components:

- Young Adults Establishing Self Sufficiency (YESS):
YESS supports former foster youth as they age out of the DCYF system and transition to adulthood. This voluntary aftercare service provides assistance with room and board, emergency services and assistance in accessing other income and support services for young adults between the age of 18 and 21. YESS is a collaborative partnership between DCYF and the Rhode Island Council of Resource Providers for Children and Youth (RICORP) to serve young adults who demonstrate skills to live independently with minimal supervision and support. In FY 2014 YESS aftercare services were provided to 331 youth.

- YESS Model Aftercare Program Services
A collaborative effort with four community providers and DCYF, the YESS program has been expanded to include youth to age 24 for supportive housing services. This program is available to youth at risk of homelessness with documented mental health issues. This program enables these young people to remain in a low cost rental unit after they reach age 24.

Other programs provided or coordinated by the CYS include a partnership with EOHHS to provide health insurance coverage until the youth's 26th birthday through the ACA extended Post Foster Care Medicaid coverage group ("Chafee Medicaid"), Life Skills, The Voice: Youth Advocacy and Leadership Board, Chafee Education and Training Voucher Program, Chafee Foster Care Independence Program, and Youth Development and Educational Support Services Team. Additional services include ASPIRE Financial Literacy Training, ASPIRE Individual Development Account, NYTD, Real Connections and Teen Grant. Data from these programs over the past few years is collected and is in the process of being analyzed by community organization.

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

Since the 1990s, DCYF has been moving toward a single, integrated system of care (SOC) to provide individualized, family-focused, community-based and culturally appropriate services to children and families throughout the state. Initial steps toward this integrated system of care included the creation of regional Family Service Unit offices and a focus on community-based services. Along with this, DCYF developed a single information management system, the Rhode Island Children's Information System (RICHIST) that includes case management, staff management, financial management, provider management and policy and procedure management functionality. RICHIST also supports demographic, behavioral, medical and legal data collection and a range of continuous quality improvement tasks. During this time, DCYF received multiple grants to assist in moving toward a system of care that focus on family centered planning and community based services as an alternative to more restrictive interventions for children and youth.

Building upon these initiatives, DCYF implemented a two-stage approach to realize an integrated system of care with our provider community. First, DCYF established the Family Care Community Partnerships (FCCPs) to address the front-end needs of the child welfare and children's behavioral health systems (January 2009). During the second phase, DCYF implemented a redesign of the provision of services to children, youth and families legally involved in the child welfare and juvenile justice system through the newly developed Family Care Networks (July 2012).

DCYF has been assisted in this transformation with two SAMHSA grants: the SAMHSA Expansion Planning Grant for which a blueprint process was submitted in September 2012 and the current Expansion Implementation Cooperative Agreement. The goals of the statewide SOC Expansion Implementation grant initiatives are to:

- (1) develop a cross-agency infrastructure with the capacity to coordinate the SOC for children and youth with SED and their families;
- (2) develop and sustain a comprehensive array of mental health and recovery support services for children and youth with SED and their families across service systems that are delivered by a well prepared, responsive and diverse workforce;
- (3) be driven and guided at every level and in every setting by the diverse children, youth and families with whom DCYF works; and
- (4) through strategic communication and social marketing increase support among families/youth, providers and public opinion makers.

System of Care Development

DCYF has been contracting with a broad range of vendors to provide publicly funded programming throughout a continuum of services for the population of children and families it serves which include child welfare, children's behavioral health and juvenile corrections. All of

these services are provided on a statewide basis. On an annual basis, the Department provides services to approximately 9,000 children/families.

Through other federal initiatives; e.g., the Community-Based Child Abuse Prevention (CBCAP) program, the DCYF has integrated the work of the Family Care Community Partnerships (FCCPs) to engage a statewide network of primary, secondary and tertiary child abuse and neglect prevention programs. DCYF has supported and encouraged the development of a community based system that can provide strong prevention-focused support programs to assist in diverting families from DCYF involvement, where appropriate. With this approach, a much greater emphasis is being placed on community-based family support and services that embrace the positive wraparound values and principles of a system of care which focuses on wellness and community with less reliance on and reduction in out of home placements in residential programs.

All federally funded programs complement the state's continuum which include prevention and early intervention programming for family preservation and support and substitute care living arrangements with relatives, kinship, and non-relatives.

DCYF's system of care transformation has required the development of a responsive continuum of community behavioral health services and supports in each region of the state for children with serious emotional disturbance and their families. The goal is to enhance the system's ability to provide increased access to community-based services and natural supports that are strength-based, family driven, youth guided, culturally and linguistically competent, and that promote the family's self-efficacy.

Family Care Community Partnerships

The state is divided into four geographic regions. Each Family Care Community Partnership is assigned to one region. The largest FCCP covers the region containing the cities of Providence, Pawtucket, Central Falls and Cranston. This region is home to populations that are among the most diverse, poorest and most underserved in the state.

The primary focus of the FCCPs is to improve the lives of children and families not open to the DCYF through prevention and the provision of effective community-based services and supports using a wraparound planning model to avert children, including those with SED or at risk of SED, and their families from becoming involved with DCYF. In the latest semi-annual FCCP report, the percentage of cases eligible for services based on a child being identified as having SED at time of referral averaged around 20% of referrals. The remainder of the children and youth were identified as being at risk for child abuse/neglect which are also factors for developing mental health/behavioral health issues. The main concerns of both the caregiver/family and the child/youth at intake were very similar;

- caregiver/family identified 43% mental health concerns followed by 41% who had stressful life events
- child/youth identified 41% mental health concerns followed by stressful life events 40%.

Family Care Community Partnerships provide the following:

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

To support the FCCPs, DCYF implemented the Rhode Island Family Information System (RIFIS), a web based data information system designed to support the collaborative work of families and providers in the FCCPs. RIFIS captures data and outcomes to assist each stakeholder in the system with better management tools to assess effectiveness. Quarterly or semi-annual reports and annual reports that reflect outcomes and adherence to practice standards are part of the work being accomplished.

Family Care Networks

Two statewide Family Care Networks (FCNs) – Ocean State Network for Children and Families (OSN) and the Rhode Island Care Management Network (RICMN) – were awarded contracts to provide a full array of integrated home and community-based and foster home and group care services and to partner with families and the Department to prevent or reduce out of home placement of children and youth with SED. On July 1, 2012, the Family Care Networks became operational for families who have children who are formally involved with DCYF and who are in need of, or at risk for, out of home placement. For FY 2013, 2,252 families (unduplicated count) were referred to the FCNs for services.

To assist in evaluating the strengths and needs of children and youth, DCYF has implemented the use of the Child and Adolescent Needs and Strengths (CANS), a standardized, nationally validated functional assessment that includes a section on trauma. Children and youth who enter residential care are assessed using the CANS and reassessed quarterly and when they are discharged from placement. Data from the CANS is collected and shared quarterly with all stakeholders to monitor and assess the needs of children and to improve practice. The trauma modular has been added to the CANS.

Rhode Island Child Welfare-Early Care Partnership

DCYF secured funding for the Rhode Island Child Welfare-Early Care Partnership (2012) “to secure an infrastructure across early care systems to ensure that infants and young children in the child welfare system receive quality early care and education services which ameliorate the effects of exposure to trauma and improve their social and emotional well-being to better address barriers to permanency.” DCYF has implemented an early childhood mental health competency and endorsement system that will provide a framework of knowledge, skills, and reflective practice experiences for the early childhood workforce. Through the establishment of a cooperative agreement between DCYF, the Rhode Island Infant Mental Health Association and the Bradley Early Childhood Research Center, several planning meetings have commenced to plan strategically for implementation of foundational training on infant/toddler social emotional health with child welfare and other associated staff. Rhode Island has also purchased nationally recognized infant mental health competencies from the Michigan Association for Infant/Toddler

Mental Health. These competencies are and will continue to be integrated into workforce knowledge guidelines and early learning standards in partnership with the Rhode Island Department of Education.

Treatment Services

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

A range of treatment options is available to children and adolescents statewide through the Community Mental Health Centers (CMHC) and other community based family service or mental health organizations. Available treatment options include outpatient individual, family and group therapy; intensive home-based services; respite services; behavior management; psychiatric assessment; and treatment, including medication management, psychological assessment, inpatient services and sexual and substance abuse treatment. Each CMHC has a Children's Services Program administered by a children's services coordinator, and provides a range of services that include emergency service, outpatient services, and intensive home-based treatment.

A key result in the Truven report was that youth in Rhode Island in 2011 were more likely to have been diagnosed with ADHD compared to other New England states. During 2014, 6099 children under age 18 were treated at CMHCs. 24% of these children had a primary diagnosis of attention deficit disorder, 22% had depressive – related disorders, 16% had anxiety disorders and 13% had conduct disorders (RI KIDS COUNT Factbook). In addition to the above services and programs, day hospital services targeted for children and adolescents with severe behavioral, developmental, and emotional disorders are available at nonprofit child and adolescent psychiatric hospitals. Local school departments administer day programs for behaviorally disordered children and adolescents that are available to out-of-district youth. The provider for mental health services for children in DCYF care in out-of-home placement is Neighborhood Health Plan of RI (NHP).

Inpatient Psychiatric Services

State funded inpatient psychiatric services for children and adolescents are provided by three private nonprofit hospitals. DCYF provides the funding and the care management for fee-for-service Medicaid and uninsured youth opened to the Department who require this level of treatment. All other publicly funded children are served by their RIte Care managed care providers.

Acute Residential Treatment Services (ARTS):

ARTS is a short term acute psychiatric hospital step-down or diversionary program. These programs have complete diagnosis and assessment capabilities with psychiatric and nursing services funded by health insurance or Medicaid. This service provides short-term stabilization and treatment necessary to prevent re-hospitalization or long-term residential treatment. The capacity is 16 to 18 beds.

Partial Hospitalization Programs (PHP) and Early Childhood Day Treatment Programs

There are six PHP programs for children and youth that provide 4-8 hours per day for 5-7 days per week. There are two day treatment programs for early childhood which address children with serious emotional disturbances and pervasive developmental disabilities.

Enhanced Outpatient Services (EOS)

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

Emergency Services Hotline and Mental Health Emergency Interventions for Children:

There are ten provider agencies of Mental Health Emergency Interventions for Children. Each has a hotline that is confidential and free to families who will receive a call back within 15 minutes, and, if needed, a face to face assessment within two hours with a child competent clinician who can assess the situation and assist families toward the least restrictive option for appropriate care. Monthly data show that provider agencies received 2872 phone calls in CY 2014 and 926 were face to face mental health emergency interventions. These ten providers also reported seeing 3897 children and youth in CY 2014. 2461 or 63% were seen in a hospital setting.

Treatment Services Available through the System of Care (FCN)

Residential Treatment Programs (RTPs): These residential treatment programs are long term sub-acute psychiatric step down programs. RTPs are self-contained campus settings that provide an intensive level of casework, therapy and educational programs. The RTPs in state include Harmony Hill School and St. Mary's Home for Children. ACE and Ocean Tides are also RTPs that provide this service for youth in the juvenile justice system and provide services for youth with SED or at risk for SED.

Residential Counseling Centers (RCCs) and Staff Secure Group Homes: RCCs and staff secure group homes are community-based psychiatric hospital step-down and diversionary programs. These programs are designed to address the needs of SED youth and children within a continuum system of care approach. Services include on-site group, individual and family counseling, medication maintenance, psychiatric evaluations and case management. There is a high staff to resident ratio with overnight awake staff.

Group Home Special Population-Sex Abusing Youth: These specialized group home programs provide a structured treatment milieu as an alternative to residential treatment for youth who have sexually abused in a community based program. These programs utilize a full

time clinician and provide special treatment approaches for sexually reactive/offender youth and intensively supervised daily programs in the home, school, and community setting. There are four sites for youth ages 12 to 21.

Group Homes: Group homes provide placement for children and youth in a community –based facility that utilizes local schools and recreational and cultural services. Intensive mental health services are available and include a clinical level of service that is part of DCYF’s hospital diversion and step down programming. Group homes are structured and supportive community based living environments that prepare children and youth for reunification, foster care, and adult living.

Therapeutic Foster Care: Specialized foster care programs provide professional support services to children, youth and foster parents. Individualized treatment is provided within a supportive and structured home environment. These programs help to foster positive relationship skills, ameliorate emotional conflicts related to attachment and development, and prepare youth for transition to home, long term foster care, adoption, adult living or other age and developmentally appropriate settings.

Emergency Shelters/Stabilization Respite and Assessment Centers: There are 6 emergency shelters available across the state for children and youth from birth to eighteen years of age. These are temporary placements that provide both social and mental health services to children and youth.

Transitional Living Services: Formerly referred to as the Independent Living Program, this program assists adolescents diagnosed as SED through developing skills necessary to function independently within the community. The focus is on helping older youth develop adult living skills while receiving needed mental health treatment. Under the leadership of the DCYF director, the Independent Living Program was assessed and redesigned to ensure that the young adults going through the program gain access to the necessary supports, training, and educational opportunities needed to succeed. Youth transitioning from this program may receive services from the Young Adults Establishing Self Sufficiency (YESS) program.

Other Clinical and Prevention Services

Diagnostic Assessment Service (DAS)

DCYF oversees and funds the Diagnostic Assessment Service program which is targeted for youth, age 12 to 18 referred by family court and truancy court who require intensive diagnostic assessment to determine appropriate case planning. Outpatient DAS allows youth to remain at home while being evaluated. The outpatient DAS reports are completed within three weeks of assignment. DAS reports are comprised of a psychosocial history and educational reports including educational testing and psychological evaluations with IQ testing. Based on this comprehensive assessment, a set of treatment recommendations are developed to guide the court’s disposition on a youth. During the past calendar year the number of DAS completed was 162 which represent an increase over the past two years; the total completed in CY 2012 was 131 and in CY 2013 was 102.

Evidence Based Practices

In FY15, DCYF and providers collaborated to implement evidence-based or evidence-informed programs both for community based and congregate care settings. Among those programs are Trauma System Therapy (community-based), Positive Parenting Program (Triple P), Alternative for Families – Cognitive Behavioral Therapy (AF-CBT), and Trauma Focused Cognitive Behavioral Therapy, Teen Assertive Community Treatment (TACT), Family Centered Treatment (congregate care), and Trauma System Therapy (congregate care). Both FCT and TST residential models engage family engagement and involvement with the youth while in their placement setting with the goal of supporting and preparing families for reunification. These programs added to services in the array such as Multi-systemic Therapy (MST), (community based) and for congregate care, Parenting with Loving Limits (PLL).

The department also provided extended RiteCare medical coverage to parents to support reunification efforts. As part of the overall System of Care in general and wraparound process, in particular, RI DCYF administers the Wraparound Fidelity Index EZ to families receiving Wraparound. This survey is conducted on an ongoing basis and administered by a RI family partner agency. Approximately 87% of the surveys are conducted in-person and in the family's home. According to WFI-EZ caregiver form responses collected between April 2013 and March 2014:

- 48.0% of respondents agreed or strongly agreed to the statement, *"My family was linked to community resources I found valuable."* (Item B13, N=103)

- 47.6% of respondents agreed or strongly agreed to the statement, *"With help from our wraparound team, we have been able to get community support and services that meet our needs."* (Item B25, N=102).

DCYF continues to work with the Family Care Network lead agencies, community-based providers, Neighborhood Health Plan and the Executive Office of Health and Human Services to expand existing evidence-based practice (EBP) models and promising practices, as well as develop and implement new models that have been identified as having specific relevance for the children and youth involved or at risk for involvement with DCYF.

FCCP

The FCCP were developed to provide necessary community based support and wraparound services for children and families who are at risk for DCYF involvement for child maltreatment; children who are mentally, emotionally, and behaviorally challenged; or youth who are involved with juvenile corrections. Community organizations such as schools and mental health organizations or the family can make a referral to the regional FCCP requesting services. Each regional FCCP provides community education at least once a year. The number of families receiving services through the FCCP is as follows:

- July 1, 2010 - June 30, 2011 Total: 2,237
- July 1, 2011 - June 30, 2012 Total: 2,452
- July 1, 2012 - June 30, 2013 Total: 2,135
- July 1, 2013 - June 30, 2014 Total: 1,610

An estimated 20% of the children receiving services through the FCCP are children with SED. The number of cases referred to the FCCP is lower in 2014 than previously in part due to more children and families being opened to DCYF. Those children referred by DCYF to the FCCP are those at risk of further DCYF involvement, residential care, trauma through domestic abuse in the home and neighborhood, and involvement in the juvenile court system. Many families seek help due to homelessness and lack of support to provide for their children. Most of the children live in the four core cities in the state.

Project Early Start services are available through the FCCPs; these in-home services to families with children birth through five years of age that include care management, nutrition counseling, child development/education, parent aides and recreational activities.

Wayward/Disobedient Diversion Services:

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

Legislative Initiative Article 23: This initiative (signed into law in 2001) ensures that appropriate community services have been offered to families and children prior to the filing of a wayward petition by virtue of a disobedient behavior petition with the Rhode Island Family Court. When a parent or guardian wishes to file a petition alleging that a child in their care is wayward by virtue of disobedient behavior, they contact the local police department which, if appropriate, has a release of information signed by the parent or guardian and instructs the parent to go to the local agency approved by DCYF for an initial screening/assessment. An assessment and service plan are provided at no cost to the family. The agency then engages the family in a course of treatment/intervention or refers them to a more appropriate agency. During FY 2014, 420 youth received services from seven community agencies.

Youth Diversionary Programs (YDP): YDP, which was established in 1993, is a community-based program for youth between the ages of 9 and 17 who are at risk of being involved in the juvenile justice system. The goals of the YDP are to divert youth from the juvenile justice system and to prevent youth from involvement with DCYF. Crisis intervention, family mediation, advocacy, counseling and referrals are provided for up to 90 days. Four community agencies have provided services to 245 youth (from July 1, 2013 to June 30, 2014) FY 2014.

Youth Transition Centers (YTC): YTC is a public/private collaboration between Tides Family Services, Inc. and the Juvenile Probation/Parole for high risk youth on probation or leaving the Rhode Island Training School. Youth receive services in the community with an emphasis on strengthening families by integrating outreach and tracking services from the Tides Family Services. YTC provides both prevention and rehabilitative services to around 85 youth per year.

Other Community Prevention: DCYF also administers several programs and services through other federal funding. These federal programs all align in a continuum of care and service to support and help guide the efforts to protect the most vulnerable population of children and to promote family strengths and healthy functioning. The Safe Families Collaboration Program

with the Coalition Against Domestic Violence provide Domestic Violence liaisons that are co-located at DCYF and at the four FCCPs to provide families the support, consultation and advocacy necessary to address issues of domestic violence. Other prevention services include educational outreach and advocacy to prevent child abuse.

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

DCYF continually addresses the access to services, service delivery, personnel makeup, training, practice standards and contracts to ensure that the needs of diverse social, ethnic and sexual gendered minorities are being met. Data from both the FCCPs and the FCNs is analyzed and used to improve practice and outcomes for children, youth and families.

DCYF is planning to charter their own Diversity Council recognizing the critical importance that diversity of thought, related to dissimilar backgrounds and experiences, plays in the delivery of services to our children, youth and families. The mission and role of the council will be to guide DCYF on developing organizational changes and strategies that will advance the goals of diversity and inclusion in the workplace.

The following are other examples of efforts by DCYF to address this issue:

- Coordinating a cultural training curriculum developed through the Rhode Island Community and Justice's Disproportionate Minority Contact Project with the Child Welfare Institute.
- Increasing the cultural and linguistic diversity of staff.
- Providing training on cultural sensitivity, cultural diversity, working with culturally diverse populations, building awareness of and working with Lesbian, Gay, Bi-sexual, Transgender, Queer, and Questioning (LGBTQQ) populations on a regular basis for direct staff, supervisors, management and our community partners.
- Having a large range of contracted interpreter services available statewide.
- Requiring in all DCYF and Network contracts a minimum competency skill set and support of local culturally vital organizations in the community.
- Administering the second round of a rating tool through the Implementation Cooperative Agreement to access the level of a culturally and linguistically competent approach of the FCN and FCCP

A LGBTQ committee was specifically formed to address the unique needs of youth in state care. The committee is comprised of DCYF, system of care networks, network and community providers, gay and lesbian advocates and defenders and Youth Pride, Inc. A two day training is being developed to cover adolescent identity development, legal responsibilities and practice recommendations. DCYF is working on developing a SOGOE (Sexual Orientation, Gender Identity, and Expression) policy and procedure. Guidance on working with transgendered youth is also being addressed.

Professional Development and Community Education

DCYF, through the Child Welfare Institute, maintains its commitment to ensuring that supervisors in Family Service Units and Juvenile Probation staff have the skills, knowledge, and experience to provide effective leadership to promote improvements in safety, permanence and

well-being for children, youth and families. The Child Welfare Institute continuously adjusts its training curriculum to support the training needs of department and community provider staff. The Department has made workforce wellness for DCYF staff and staff within the provider community a substantive goal as it directly relates to the ability of the system to deliver quality care and services to children and families.

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, Division of Behavioral Healthcare Services

The General Laws of Rhode Island provide the statutory authority for the delivery of services for individuals with mental illness, substance abuse or gambling prevention and treatment needs within the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). Chapter 40.1-1 et seq includes specific duties and responsibilities of BHDDH for the provision of behavioral healthcare services in Rhode Island, as well as requirements for the Governor's Council on Behavioral Health.

BHDDH's mission is to serve Rhode Islanders who live with mental illness, substance use disorders and developmental disabilities by leading innovations in prevention and quality, directing the continuum of care and guiding resources to promote safe, affordable, integrated services across the health care spectrum. Our vision is to be a leader in the development of innovative, evidence based programs that improve care delivery, strengthen the service delivery network and best serve those who use the system. in a timely, efficient and effective manner.

BHDDH strives to promote a recovery oriented system of care (ROSC) philosophy across the Division of Behavioral Healthcare and requested that the state planning council, the Governor's Council on Behavioral Health, convened a subcommittee in 2010 to make recommendations regarding the establishment of a recovery oriented system of care. The subcommittee worked on strategies involving provider training, regulation changes and consumer recovery groups. The Division is planning to revisit its regulations over the course of the year, in collaboration with the Governor's Council on Behavioral Health, to ensure our policies, practice and programs reflect our commitment to ROSC.

BHDDH has also been an active supporter of the development of the Anchor Community Recovery Centers, specifically the peer-based programs that support individuals in recovery and RICARES, which is the state's grassroots recovery organization. BHDDH's support has included allocating SABG funds to these two organizations. BHDDH also allocates MHBG funds to support two mental health peer-based recovery organizations, NAMI-RI and MHCA-RI.

The Division of Behavioral Healthcare is comprised of staff with expertise in Mental Health and Substance Use Disorders, Prevention, Intervention, Treatment and Planning that work collaboratively to provide monitoring, oversight, program development, planning, contract

development and critical incident review to all of the state's licensed behavioral healthcare providers. The Division also oversees a prevention system consisting of five components:

1. municipal task forces (coalitions) established by the Rhode Island Substance Abuse Prevention Act (RISAPA) and funded through the Substance Abuse Block Grant.;
2. Student Assistance Programs also established by legislation and funded by the SAPT Block Grant;
3. the Enforcing Underage Drinking Laws program;
4. the Synar program and
5. the State Epidemiology and Outcomes Workgroup (SEOW), which supports data-driven planning across the BHDDH's behavioral health system.

As of FY 2011, DBH incorporated the formerly separate Divisions of Integrated Mental Health and Substance Use Disorder Treatment along with Substance Abuse Prevention. The functions formerly divided between Mental Health and Substance Abuse continue to combine as staff is educated and cross-trained to learn systems, contracts and best practices in Mental Health, Substance Abuse and Co-occurring treatment.

For the first time BHDDH has also supported the incorporation of the two Mental Health and Substance trade organizations to finally become on integrated program called The Substance Use and Mental Health Leadership Council of RI. *(Formerly RI Council of Community Mental Health Org. and DATA of RI, Inc.)*

The Division plays a leading role in the development of the community-based behavioral healthcare system in Rhode Island. It does so in a number of ways; by developing and monitoring new contracts, by writing, monitoring and implementing grant-funded projects, by program monitoring and regulation and by collaborating with other state agencies, public bodies and consumer and provider groups. As a result of these activities, the Department has helped foster a dynamic and innovative behavioral healthcare system.

DBH does not provide direct services. It administers a system of care that provides clinical treatment services and supports for over 42,000 individuals. The system of care consists of 37 administrative providers with 119 service sites that are community-based with state and federal funding that is augmented by the combine Mental Health and Substance Abuse Block Grant and discretionary grants from the Centers for Mental Health Services and Substance Abuse Treatment. The Division of Behavioral Health Services (DBH) is responsible for the planning, coordinating, and administering of comprehensive statewide systems of substance abuse prevention and the promotion of mental health; screening and brief intervention; early intervention and referral, substance abuse and mental illness clinical treatment services, and recovery support activities.

Adult Behavioral Health Services

Community Mental Health Centers

State law specifies that Rhode Island's publicly-funded community service system for persons with mental health disorders be provided through contracts between BHDDH and community providers. Currently BHDDH contracts with eight (8) such provider agencies, six of which are licensed as Community Mental Health Centers (CMHCs) and two of which are Specialized Service Agencies that provide behavioral healthcare services. Each of the state's eight geographical catchment areas has a CMHC that assumes statutory responsibility for assuring that a comprehensive range of services are available for adults with severe and persistent mental illness. A total of 42,689 persons with behavioral health needs were served in FY 2014 in a Rhode Island's community behavioral health system. 35,414 individuals over the age of 18 received mental health services (n=23,933) or substance abuse services (n=14,447), and 7,272 individuals under the age of 18 received mental health services (n=7,059) or substance abuse services (n=343). Each CMHC provides:

- **Wellness Promotion** which includes a) consultation to other health, mental health, law enforcement and human service providers to assist them to recognize and address behavioral health problems among their clients, and b) community education regarding the nature of mental illness and development of a positive attitude toward its prevention and treatment.
- **Emergency Service** which is an immediate response by mental health professionals 24 hours per day, 7 days per week, to anyone experiencing a psychiatric emergency.
- **General Outpatient Services (GOP)**. GOP services offers a range of diagnostic, clinical, and educational services that may vary in intensity level for persons suffering from behavioral health issues that adversely affect their level of functioning, but not severe or long-lasting enough to be disabling (usually less than 6 months).
- **Community Support Service (CSP, Community Support Program)** is the provision of care to individuals for persons with "Severe and Persistently Mental Illness (SPMI). All CSP-eligible clients have access to an array of intense, community-based treatment, rehabilitation and support services.

In addition, the CMHCs are required to provide Health Home services to the SPMI Medicaid population and may provide the same service to their GOP population. All of the CMHCs are enrolled in CurrentCare, the state's Health Information Exchange. BHDDH also funds a variety of consumer-operated services that provide alternative support for the person to engage in the process of self-discovery and recovery.

BHDDH has developed a continuum of specialized substance use disorder services for adolescents and adults in need of treatment for alcohol and drug dependence and abuse with multiple entry points. The continuum includes prevention and treatment services (e.g. detoxification services, outpatient services and residential treatment) and recovery services. The CMHCs are not required to provide substance abuse treatment services, but all do provide substance abuse and co-occurring services within the continuum. The CMHCs have become significant providers of substance abuse treatment outpatient services within their local communities, along with other BHDDH licensed Behavioral Healthcare Organizations (BHOs) that solely or primarily provide SUD services, there is a strong representation of the continuum of services included in the planning process of this grant. Many of the CMHCs have contracts

with the Department of Corrections, local schools, hospitals, and primary care providers within their service/catchment areas.

The following are examples of the array of services provided by these community organizations through Block Grant contracts:

- Mental health and rehabilitation services
- Outpatient mental health and substance use services
- Case management
- Psychiatric rehabilitative services
- Screening, assessment and diagnosis
- Employment services including vocational and educational assessment, Individual Placement and Support, Supported and Transitional employment, Job Finding/Development
- Peer Supports: For more detail, see “Recovery” section 17 in Environmental Factors.”
- Housing services including supervised apartments, psychiatric rehabilitation residential services and recovery housing
- Drop-in Centers
- Medication maintenance
- Family treatment
- Case management services
- Integrated treatment services to CSP clients through the Behavioral Health Homes
- Emergency or crisis services including assessment
- Services for persons with co-occurring (substance abuse/mental health) disorders; and
- Other activities leading to reduction of hospitalization, including the Respect Program
- Workforce development
- Outpatient services for individuals with a primary diagnosis of substance abuse disorder, including intensive outpatient and partial hospitalization
- Medication assisted treatment
- Gender specific residential treatment for women, including residential treatment for pregnant women with substance use disorders and their children
- Transitional, short-term and long-term substance use disorder residential treatment
- Peer Wellness Coaches
- Recovery Coaches
- Recovery Centers
- Trauma informed care

Other Community Providers of Behavioral Healthcare Services

BHDDH also works closely with other community services providers that it does not license but play an instrumental role in the behavioral health continuum of services. These include:

Community Action Agencies (CAAs), Homeless Service/ Supportive Housing Providers and Family Service Agencies help low-income people transition out of poverty and into social and economic self-sufficiency. Some Community Action Agencies also provide behavioral health services. Some of those CAAs have cooperative agreements or working relationships with CMHCs to address the needs of clients who exceed their outpatient level of care. This is true of

the new PATH provider, the House of Hope, which will provide clinical services by MOU with The Providence Center.

Community Health Centers work to provide high-quality, comprehensive health care. Rhode Island's nine community health centers provide preventive primary medical, dental and behavioral health care services, including dental services, to over 146,000 individuals at 29 locations across the state.

BHDDH funds a Small Business Program to encourage clients' vocational independence in a competitive environment. The program provided the initial capital investment and annual grants to nonprofit organizations to develop and operate small businesses. Such enterprises employ severely mentally disabled adults. Two businesses are now operating under the Small Business Program: Cookie Place, a bakery, and New Leaf, a plant and garden store.

Discretionary Grants

While the Department no longer has direct fiscal authority over Medicaid reimbursable services, it has enhanced the range of behavioral services available to the community through an increased number of SAMHSA grants. These include:

Pathways in Transition from Homelessness (PATH): Provides outreach to individuals experiencing homelessness and connection to the State's Continuum of Care.

Healthy Transitions: Now is the Time Healthy transition grant: this grant addresses the needs of youth and young adults ages 16-25 with Serious Emotional Disturbance, Severe Mental Illness and/or Co-Occurring Disorders in two Rhode Island communities. Two cities, Warwick and Woonsocket, will build on existing partnerships with youth and family representatives, local service provider agencies, educational, recreational, and church and other community stakeholders to do several things. These services involve a number of Evidence Based Practices delivered within the Coordinated Specialty Care (CSC) model. The proposal's goal is to transform a divided service system that provides different types of services, using different eligibility criteria, to youth/young adults of different ages. Achieving the goal involves making structural changes at both state and local community levels.

BRSS TACS : The focus of this project is to increase the availability of competent Peer Recovery Support Services and ensure adequate funding for Peer Recovery Support. The Rhode Island BRSS TACS team is composed of peers, behavioral health community leaders, providers, advocacy agencies, academicians and representatives from the RI Medicaid office, Department of Health and Certification Board. **For more detail on the mental health and substance use disorder Peer programs, see "Recovery" section 17 in Environmental Factors.)**

SYNAR: BHDDH is the designated state agency responsible for ensuring compliance with federal Synar Amendment mandates. BHDDH, with assistance from the Division of Taxation and municipal police departments, oversees the conduct of the annual Synar Survey and on-going enforcement of the State's statute prohibiting the sale and distribution of tobacco products to underage children. BHDDH reports the results of the annual Synar Survey and the disposition of violations of State statute that are heard in District Court; and also details prevention efforts

conducted by community prevention coalitions to reduce youth access. Since 1998, consistent with State statute (RIGL 11-9-13) inspection and enforcement provisions, BHDDH has contracted with municipal police departments to assist in conducting the annual Synar Survey and engaging in on-going enforcement efforts.

Partnerships for Success: Twelve (12) Rhode Island communities have received funds for substance abuse prevention activities targeting underage drinking and youth marijuana use. These communities were identified as high need based on their youth prevalence rates and a set of social indicators related to negative consequences of substance abuse based on the 2013 State and Community Epidemiology profiles. (See Table 4 below). Funding for the communities began July 1, 2014 and ends September 29, 2018.

Cooperative Agreement to Benefit Homeless Individuals: RICABHI is targeting veterans and individuals experiencing chronic homelessness who have substance use disorders, serious mental illness, or co-occurring mental health and substance use disorders. It will enhance the state's infrastructure by ensuring they have access to treatment, permanent supportive housing, peer and recovery supports, and mainstream services. The project will provide services to 300 individuals in housing over 3 years. The vision of this project is to create a comprehensive system to address homelessness, where people are housed successfully, have access to a range of person-centered services that promote residential stability and recovery. This vision will be achieved by creating an infrastructure within the state agencies and community based providers that are efficient, effective, and seamless to the person accessing services. As a result of the RICABHI, BHDDH and its partners in the community will: 1) improve statewide strategies to address planning, coordination, and integration of behavioral health and primary care services, and permanent housing to reduce homelessness; 2) increase the number of individuals, residing in permanent housing, who receive behavioral health treatment and recovery support services; and 3) increase the number of individuals placed in permanent housing and enrolled in Medicaid and other mainstream benefits (e.g., Supplemental Security Income/Social Security Disability Insurance [SSI/SSDI], Temporary Assistance for Needy Families [TANF], Supplemental Nutrition Assistance Program [SNAP]).

State Adolescent/Youth Planning Grant: The Rhode Island Youth Treatment Planning project will allow the State the opportunity to establish a blueprint for the creation of a unified, recovery focused service approach for youth ages 12-25 with substance use disorders and/or co-occurring substance use disorders or mental health conditions. The Department has identified goals and objectives around the current gaps, norms, policies and resources that will, when coupled with the required interagency council and its subcommittees, improve access to and quality of services.

The key feature to our plan is the re-invigorating of the Children's Cabinet which will be essential to implementing the goals and objectives of the project. The current system is siloed and fragmented. The project proposes to systematically address the system's breakdown at the highest level of State Government, to develop policies (from programmatic reform to health insurance parity), fiscal supports, and the workforce capacity necessary to carry out the goals and objectives. The strategies will allow the State Departments to leverage collective resources,

ensure that the voice of individuals served and their families in the development of policies and practice and the exploration of appropriate statutory response.

Eleanor Slater Hospital

Rhode Island has a unique “State” hospital system in that long-term inpatient care is provided at the state operated general hospital and acute psychiatric care is provided by private hospitals. Decisions around acute psychiatric hospitalizations are generally made by the hospitals, often, particularly after hours with the assistance of Qualified Mental Health professionals with whom they have contracts. However, behavioral health crises among uninsured consumers are managed through BHDDH’s “RESPECT” contract with the Providence Center, which uses state money to provide an array of diversion, hospital alternative and psychiatric hospitalization (at Butler Hospital) for this population. As will be noted later in this narrative, detox services to the uninsured are also covered under the “RESPECT” contract.

The goal for reduction of hospitalization is that long-term care hospitalization should be provided only for those seriously mentally ill adults for whom community services are not available.

Substance Abuse Treatment Services

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is the co-designated single state authority (SSA) for substance abuse treatment and prevention services. The two major changes in the structure of public behavioral healthcare services described in the introduction, the ACA Medicaid expansion and the “carve-in” of behavioral healthcare services have initiated significant changes to the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), substance use disorder treatment services.

The “carve-in” of state dollars has limited BHDDH’s direct funding authority to Block Grant and other federal grant sources. Generally, these funds are used selectively to cover services and individuals not covered by Medicaid, who are citizens of Rhode Island. An example of the types of individuals whose treatment is supported by the SATBG are those needing Medication Assisted Treatment whose plans do not cover this service. Another good example of uncovered services that are supported by Block Grant funds are Peer Support services, which have expanded significantly and play a crucial role in our system, particularly with the increasing opioid crisis by supporting individuals who are in the ER after an opioid overdose to find treatment and other recovery.

BHDDH, as the licensing authority for behavioral healthcare providers, retains oversight, quality assurance and patient protection responsibility as covered by state licensing regulations. These include the providers who deliver services contracted by the MCOs that manage the Medicaid Expansion funds. The treatment team within the Division of Behavioral Healthcare (DBH) is responsible for monitoring the delivery of an array of treatment services, across the ASAM continuum of care. It participates in program quality reviews and Medicaid audits as well responding to quality of care complaints. The Substance Abuse Prevention and Treatment (SAPT) Block Grant Monitoring Checklist is reviewed at every agency audit along with

interviews with consumers regarding the quality of care, the agencies explanations of client rights and grievance policies as understood by the consumer. The information obtained from the consumer is then feedback to the individual agencies to address in any plan of corrections required. Through the monitoring audits for the compliance with state regulations, BHDDH helps to insure that there is a comprehensive continuum of residential, crisis stabilization and outpatient services including individual and group counseling, intensive outpatient, and partial hospitalization (e.g., day hospital). Publicly funded substance abuse outpatient services are provided using Medicaid and OHHS-managed (MCO and fee-for-service) state dollars.

BHDDH continues to manage all behavioral healthcare contracts that are funded through the Block Grant and other federal grants.

In addition, BHDDH collaborates with EOHHS to assess behavioral health service needs, develop practice standards and determine the behavioral health elements of the state's Medicaid Plan.

Using Block Grant funds a single, statewide medical detoxification/acute psychiatric hospitalization program for uninsured individuals was developed under the "Respect" contract. This program provides detoxification services, including a secure unit for individuals with suicide ideation in need of detoxification. The contract also supports the use of assisting those seeking residential placement, out-patient detox and step-down services for continued stabilization.

Adult substance abuse residential treatment services are provided using Medicaid/state funds. All treatment residences are now gender-specific due to new contracting being implemented in 2013. There are seven men's and six women's treatment facilities across the state providing gender-specific and trauma informed SA treatment. Services are assessed and provided for the specific ASAM level needed, which allows for a better match of client needs to programs requirements. The 2013 contracts also required two new levels to be added: a "respite/crisis" level at one site and a "short-term transitional" level at nine of the programs. Also, the provision to support recovery housing has been formalized. All state funds for recovery housing are now implemented and monitored by an agency licensed in Rhode Island which maintains MOUs with each recovery house and requires that the programs maintain Level III of the National Accredited Recovery House standards (NARR) . Finally, the new contract encourages all providers to enhance their provision of a recovery oriented system of care by utilizing a full continuum of care and by adding and supporting recovery housing with wrap around services available as needed.

BHDDH also has a "Transition to Recovery" pilot program for individuals recently released from the Adult Correctional institution (ACI). During the recent opioid epidemic, the data began to show that 69% of the individual overdosing had no formal connection with treatment prior to their overdose and as many as one out of three had recently been released from the ACI within the last two years. This program is funded through federal Byrne Jag funds and allows for recovery housing supports with wrap around services prioritizing those who volunteer to begin taking Naltrexone one month prior to discharging from the ACI and five months following. This pilot program will allow for six months of recovery supports for those with a opioid use disorder

and a history of relapse. The hope is the data from this program will support the need for intensive services leaving incarceration.

The state has continued to fund Medication Assisted Treatment. Five agencies with twelve sites provide statewide MAT. All of the programs are funded by the Department specifically for the uninsured clients. A significant portion of the SAT Block Grant funds are used to support services and individuals that are not covered under Medicaid and in need of MAT whose insurer does not have a MAT product in their plan. Many of these individuals, including those on Medicare, were previously covered under the state's CNOM program, which has since ended. Block Grant funds pay the majority of costs for the uninsured, although a co-pay is required as a financial incentive to engage in treatment. Each case is reviewed individually to meet the federal requirements.

Also, a number of physicians who are not funded by BHDDH provide Medicaid-covered buprenorphine treatment, and many of these provide clinical services for other service providers by contract.

OPIOID TREATMENT HEALTH HOMES

By state Medicaid Plan Amendment, all five MAT providers operate Opioid Treatment Provider Health Homes (OTP-HH). Rhode Island's OTP HH program is the second in the country, and currently serves about 2500 individuals. The OTP HH's provide person-centered treatment that decreases the stigma often experienced by patients on MAT in mainstream medical care. The program monitors chronic conditions, enhances the coordination of physical care and treatment for opioid dependence and promotes wellness, self-care and recovery. The six core OTP HH services are: comprehensive care management, care coordination and health promotion, comprehensive transitional care from inpatient to other settings including appropriate follow-up, individual and family support, referral to community and social support services and the use of health information technology to link all services. The bulk of funds that support the OTP HH come from state and Medicaid funds, and among the services provided are facilitation of access to benefits. For more detail, see "Medication Assisted Treatment," section 15 in Environmental Factors.

IVDU

The Department functions as the state Opioid Treatment Authority. BHDDH staff review and monitor all exception requests, along with regular interviews with consumers regarding treatment and recovery support services. Opioid Treatment Programs are expected to incorporate evidence best practices based on SAMHSA's TIP 43. For opioid dependent patients who have required a higher level of care, dual enrollment is available for both residential and more intensive outpatient services.

The state of RI also:

- Continues to implement capacity management and wait list systems strategies.
- Continues collaboration with the Department of Health's ENCORE program (Education, Needle Exchange, Counseling, Outreach and Referral) which is an HIV (and other Blood-borne

pathogens) prevention/intervention aimed at injecting drug users (note: no Block Grant dollars were used for needle exchange activity)

All contracts with programs funded by the Block Grant include language requiring that they conduct outreach activities to intercede specifically with IVDUs, in order to provide HIV counseling, and refer individuals to treatment or medical/other support. Although not funded by BHDDH, the Department of Health (DOH) and their community programs provided a wide range of street outreach activities to intravenous drug users designed to reduce harm and refer IVDUs to treatment. In addition, BHDDH and DOH regularly collaborate. The Department is a standing member of the Department of Health-lead Drug Overdose Rescue Coalition, which also includes representatives of the medical and pharmacy treatment communities.

BHDDH staff continue to meet monthly with clinical managers of opioid treatment programs to assist them with educational, training and service enhancements. OTPs continue to have positive accreditation outcomes. Nearly half of the OTP HH's are Health Home accredited.

COMMUNICABLE DISEASES

(see Step 2)

HIV/AIDS- Rhode Island is not a Designated State.

PEER SERVICES

Rhode Island has had a Recovery Coach training program run by Anchor Recovery Center since 2007, and Peer Recovery Specialists have been RI Certification Board-certified since 2014. Peer services have expanded significantly. (For more detail, see "Recovery" section 17 in Environmental Factors.)

EMERGENCY DEPARTMENT DIVERSION PROGRAM

For some years, a relatively small number of individuals with late-stage alcohol dependency, many of them chronically homeless, have been using Rhode Island Hospitals ED to treat recurring acute episodes of intoxication. Typically, they have been picked up by EMT crews for acute intoxication and brought to the ER, treated and then released without having accepted any longer term follow up treatment. This has been a big drain on the resources of Providence's public safety department and on those of RIH's ED, while providing ineffective care for the clients' chronic conditions. BHDDH, working in partnership with the Providence Safety Commissioner, community providers and consumers, and with support from the Legislature, developed a proposal for a diversionary site where the consumers can be brought before they are in a medical crisis, treated by medical staff and peers and connected to longer-term outpatient treatment. Legislation was passed to allow EMTs to do an assessment for medical risk and transport clients to the diversion site without having to bring the clients to the hospital ED. In 2014, the Legislature granted funds for the program, called STOP. The state grant will be supplemented using Medicaid/state match funds. SAT BG dollars may also be used to support peer services to the program. The Providence Center, the state's largest CMHC, was awarded the STOP contract via a RFP. We anticipate a start date in fall of 2015.

WOMEN SPECIFIC TREATMENT, INCLUDING CARE FOR PREGNANT WOMEN

Publicizing pregnant women as priority for admission into publicly funded substance abuse treatment programs:

Public Outreach/Awareness: Information about Pregnant women as a priority population for admission to licensed substance abuse treatment programs and SAPT Block Grant funded programs is integrated into BHDDH funded trainings, including trainings for Health Homes and Mental Health workers. BHDDH to publish priority populations for admission to licensed substance abuse treatment programs on website and in offices.

Targeted Information: flyers have been and will continue to be sent to the Department of Human Services including WIC Nutrition, and Home Visiting Programs, Department of Health, DCYF, Community Action Programs, Federally Qualified Health Centers, and hospitals. The 24 Hour Helpline greeting will inform all callers of pregnant women as a priority for admission into licensed substance abuse treatment programs, and programs receiving Block Grant funding through BHDDH.

Policies: All agencies receiving public funding for substance abuse treatment must have written policies around how they will publicize priority populations

Interventions: BHDDH reviews agencies' adherence to their policies during licensing and agency audits. The SAPT Block Grant monitoring Checklist is utilized at each audit that address women specific and dependent children requirements. Peer Review committee also monitors these issues during agency reviews, and will report outcomes to the Department of Behavioral Healthcare and a formal letter to the Governor as required.

Sanctions: Corrective Plans of Action and/or sanctions are mandatory for any agency or program receiving Block Grant funding that is not in compliance with publicizing that pregnant women are priority for admission. No sanctions have been implement since the last BG application.

There are a number of women-specific programs that are Medicaid funded and supplemented using SAT funds. Six of the twelve residential treatment programs are for women. The Department pays the state share for Medicaid eligible residents and the full cost for uninsured individuals. In addition, state funding was used for Title 19 match funding for the state's 1115 waiver program, Rite Care.

EASTMAN HOUSE - (RI 100212). 16 bed residential program for adult women. Referral to medical/prenatal services provided. Specialized prevention programming for children of women in treatment also provided. Located in Cranston this program serves women statewide. Clients can be dually enrolled in methadone treatment.

KING HOUSE (TriHab Residential) - (RI100220). 13 bed residential program for adult women. Although the program cannot physically accommodate children, a wide range of medical/prenatal services are available through relationship with local health center. Located in Woonsocket this program provides statewide services. Clients can be dually enrolled in methadone treatment. The current provider of this program, Gateway HC (CMHC)/Lifespan, will end its involvement on September 1, 2015. Negotiations are underway to re-contract with an identify a new provider.

SSTARBIRTH – (RI100824) – Located in Cranston, this program is a specialized 14 bed residential program for pregnant/postpartum women and their children. . Includes parenting programs, linkages with vocational services, relationship with prenatal services, and close relationship with Child Welfare services. Clients can be dually enrolled in methadone treatment.

PHOENIX HOUSE- (RI100238) – The Ottmar Residential Treatment program for women is a 16-bed facility. This program cannot physically accommodate children, a wide range of medical/prenatal services are available through relationship with a local Health Center. Clients can be dually enrolled in methadone treatment.

The PROVIDENCE CENTER- (RI100428) – The “Road to Recovery” Women’s Program is located in Pascoag. They are licensed for 22 beds. This program cannot physically accommodate children, a wide range of medical/prenatal services are available through relationship with a local Health Center. Clients can be dually enrolled in methadone treatment. This program however is scheduled to move to a new location in the fall. After several additions to the new location site children may be able to accommodate children as well.

ADCARE of RI – This facility has two state-funded “respite” beds. These beds are general for respite services for women who are pregnant, medically compromised or are at high risk while awaiting placement in a residential level of care. This is a residential level of care with nursing services and supports available.

Most of these residential programs have an outpatient/IOP component. In addition, there is a non-state-funded specialized outpatient program:

In addition to the adult residential programs covered under the new contracts, there are two other women-specific programs:

CARITAS HOUSE - (RI 300028). 16-bed residential treatment program serving adolescent females. Services include individual, group and family counseling, including trauma informed counseling and specialized counseling for girls who have been sexually or physically abused. This population of young women of child-bearing age is considered to be at extremely high risk for becoming pregnant and/or contracting STDs. Caritas House also provides for outpatient and recovery support services. Located in Cranston, the program serves adolescents from throughout Rhode Island.

PROJECT LINK – Women and Infants’ Hospital (RI100949): Provides specialized outpatient services for pregnant/parenting women or women of child-bearing age with co-occurring

disorders. Clients can be dually enrolled in methadone treatment. With the support of case management, pregnant and parenting women with co-occurring substance abuse and mental health problems were able to access a care plan that included medical services, parenting classes, and life skills classes, in addition to substance abuse counseling and support for mental health issues. Project Link is not funded through BHDDH.

To ensure compliance, the state contracts with the above-mentioned agencies (excluding Project Link) to provide women-specific services. Additionally, all contracts for general outpatient and methadone services included a listing of priority populations, which included pregnant injecting drug users, pregnant women, and women who are in treatment and working with the Department for Children, Youth and Families toward reunification with their children (e.g., parenting women). All contracts also require that the prime contractor **publicize** that pregnant women would receive preference in admission for treatment. Finally, all contracts require that programs serving pregnant or parenting women provide, or arrange for primary medical care, pediatric care, child care, case management, transportation and a variety of specialized interventions for women to ensure appropriate access to treatment and other ancillary services.

Also, Rhode Island remains committed to providing comprehensive care to families, and continues to utilize a Medicaid managed care program, Rite Care, which offers both primary and behavioral health care coverage to low-income women and their children. DBH regularly works with consumers and providers in navigating this managed care system, from facilitating enrollment in Rite Care to advocating for appropriate levels and duration of care for pregnant and parenting women and their children. This community participation enables DBH to be aware of emerging issues and training needs that affect this population.

In accordance with state regulations, the Division of Behavioral Healthcare conducts bi-annual monitoring reviews of all agencies receiving block grant funds. Contracts with these agencies require submission of an annual financial report, which include all State of Rhode Island payments, Medicaid reimbursements, and expenditure of funds.

In bi-annual monitoring reviews, BHDDH conducts record and site reviews for all contracted agencies. In conjunction with the licensing unit, the team looks for compliance with specifications outlined in contracts to address the needs of this population. Review of records identifies a program's ability to coordinate prenatal or other healthcare, and ability to link with community resources. Review of agency policies provided information on compliance with prioritization of this population, management of any waiting list and publication of prioritization

BHDDH also meets regularly with advocacy groups, treatment providers, the Department of Corrections, the Department of Health, and other sources of referral in an effort to ascertain the adequacy of efforts to provide services to this population. The Department was frequently used by providers and consumers to facilitate referrals and assist in the process of accessing treatment services. Issues relating to access to treatment for DCYF-involved individuals are addressed in Governor's Council on Behavioral Health Meetings attended by consumers, providers, legislators, and representatives from DCYF and BHDDH. Adverse incidents and complaints affecting our population are received by BHDDH, documented in a centralized database and

followed up with providers. The state continuously seeks to identify trends in this system, such as inability for pregnant women to access services.

The state will continue to require in the contract with treatment agencies a preference for pregnant women in admission policy; continues to require all state-funded treatment agencies to publicly post signage describing the admission preference policy, which the state has distributed to all providers for posting. BHDDH requires that providers submit a standardized weekly report of clients on wait lists identified by priority population status, placements of those previously wait-listed and interim services provided. The Department continues to require the provision of interim services within 48 hours for pregnant women who cannot be admitted to due to programs' lack of capacity, including but not limited to HIV and TB education, counseling, and referral, as well as counseling pregnant women on effects of substance use on the fetus, and referrals to prenatal care if necessary. DBH's Treatment Team will continue to act as a referral agent for appropriate placement of pregnant women when necessary.

Contract Specifications: Admission into state-funded treatment will continue to be prioritized in the following descending order: pregnant injecting drug users; pregnant women; injecting drug users; persons who are HIV antibody positive or have HIV disease; parents who are involved with the Department for Children, Youth & Families and are working toward reunification with their children, and whose participation in substance abuse treatment is a prerequisite for reunification; persons who while incarcerated began substance abuse treatment and continue to require additional treatment after release from prison and Adult Drug Court referrals. Also, the Provider will publicize that pregnant women will receive preference in admission for treatment. BHDDH will continue to monitor programs' compliance with contract specifications using the SAPT Block Grant Monitoring Checklist that was developed in 2010. This monitoring activity will take place biannually.

SUBSTANCE ABUSE TREATMENT SERVICES FOR ADOLESCENTS

BHDDH is the SSA for adolescents. There is a continuum of treatment services for youth that reflects the adults system (outpatient, in-patient, day treatment, residential, some aftercare). At this point, there is limited peer support. The aforementioned Adolescent planning grant recently awarded to RI by SAMHSA will be addressing the emerging changes in adolescent treatment and the need to address any gaps in the system including but not limited to improving young adult/youth peer supports and recovery housing for transitional age youth.

Recently, one SA residential treatment facility for adolescent males (Corkery House) closed. This is due to many changes in the RI landscape; the carve-in of behavioral healthcare into managed care allows for better access to the appropriate ASAM level of care, the affiliation of smaller agencies with larger Behavioral healthcare agencies and various changes in legislation around marijuana possession. The state no longer requires mandatory SA assessment for marijuana offenses but rather implements fines. This has resulted in fewer referrals for treatment, since fewer individuals are being assessed through a legal referral. The state still has another SA treatment program to service males but the closing of this program will be viewed as a trend and reviewed in the above mentioned adolescent planning grant as well.

RI will continue to offer male adolescent residential services through the Phoenix House at Wallum Lake. Their residential program utilizes intensive and comprehensive treatment interventions that include family therapy, mental health services and educational and vocational services. Treatment is provided using both individual and group therapy. Family involvement is considered as a crucial part in the treatment of adolescents with a substance abuse disorders. Several hours of classroom schooling will continue to be provided on site for all clients while in treatment, with individual support provided as needed for those pursuing a GED or having special needs.

Behavioral Health Provider Trainings

A key function of the state's behavioral health system is to conduct training activities that improve the skills of providers in delivering behavioral health services.

Through a contract with The Substance Use and Mental Health Leadership Council of RI. *(Formerly RI Council of Community Mental Health Org. and DATA of RI, Inc.)* supports professional development training related to behavioral healthcare. These cover a wide variety of topics that enhance practice in both mental health and substance use disorders. The curricula are developed in response to input from the state's Training Advisory Board and member agencies.

Promotion and Prevention Services

The focus of this section is primary substance use disorders, please note DCYF has additional prevention programs for children, youth and families (see descriptions in the DCYF section above)

Student Assistance

Student Assistance Programs include Universal Indirect, Problem Identification and Referral, and Selective Interventions in Junior High/Middle and High Schools. Funding is not adequate to allow for services in all high schools, much less all junior high/middle schools. BHDDH wanted to ensure the use of Project Success and its fidelity. The Student Assistance Program has contacts with approximately 8,000 students per year and we anticipate this number to increase based on the new award.

RI Substance Abuse Prevention Act

Thirty-five providers under the Rhode Island Substance Abuse Prevention Act (RISAPA). Municipal coalitions (task forces) are funded; these coalitions operate in all of the state's municipalities. Established in 1988 by state statute, Rhode Island has a statewide network of community-based substance abuse prevention coalitions, called Task Forces. Task forces have as their primary responsibility the development and implementation of comprehensive prevention plans for their respective communities, which are based on the results of a needs assessment. Task Forces are funded to provide Universal Indirect, Information Dissemination and Environmental Strategies in their communities - they plan, implement and evaluate strategies, policies and programs to produce long-term reductions in substance use and abuse.

Reducing Marijuana and Other Drug Initiative

Nine providers are funded to implement and manage substance abuse prevention programming in eleven local high schools that include implementation of evidence-based programs and strategies to prevent substance use and abuse and implementation of preventive interventions with youth a high or highest risk for abuse of marijuana and other illicit drugs. The Reducing Use of Marijuana and Other Drugs initiative seeks to attain the following goals: a measurable reduction in the percent of in-school, high school-aged (grades 9 – 12) youth reporting current (past 30-day) use of marijuana and other drugs; and a measurable increase in the percent of in-school, high school-aged youth expressing disapproval of use of marijuana and other drugs. The Initiative includes recruitment with the high school and administration of a student school survey. The SSA funds the provider to provide Universal Direct to an entire grade of students, Universal Indirect to entire school population, including students and staff and Selected Indicated, Community Based, Alternatives, Problem ID/Referral, Environmental, and Information Strategies in their schools as well as their communities. As part of the MOD initiative, in FY 12-15, 4770 students were given an evidence based curriculum and in FY 14-15, 6779 students were exposed to the social marketing/social norms campaign.

Prevention Resource Center

In FFY12 a need was identified to procure a T/TA provider. The RI Prevention Resource Center (RIPRC) which is a statewide, central information sharing and training technical assistance (TTA) resource for all RI state and community-based substance abuse prevention services and their community partners was funded through an RFP process. In order to effectively target TTA resources, the RIPRC collected baseline training and technical assistance needs and organizational capacity information in 2012. Fifty (50) organizations engaged in substance abuse prevention activities were invited to complete the TTA needs assessment survey that asked about a variety of TTA topics including: organizational capacity to build effective coalitions, monitoring and evaluation, ability to offer evidence based programs and practices, ability to implement evidence-based policies, cultural competency, understanding of the Strategic Prevention Framework, knowledge of target populations, and program management. In the RIPRC needs assessment, prevention providers identified eight (8) training content areas needed to increase the capacity of communities to implement, sustain and improve effective prevention initiatives, content areas including: Public Policy and Environmental Change, Prevention Policy Development, Ethics and Confidentiality, Sustainability Planning, Survey Development and Use, Navigating Political Systems, Using Survey Data for Planning and Proposals and Implementing Focus Groups. The following six (6) key technical assistance needs were also identified: Increasing the Prevention Expertise of Coalition Members (49%), Maximizing Social Media Tools for Prevention (43%), Implementing and Using Needs Assessments (40%) Using Data for Program Improvement (29%), Engaging Key Stakeholders (29%) and Utilizing Asset Building Multidisciplinary Programming (26%). The training and technical assistance plan is revised annually based on the needs assessment which is conducted bi-annually.

One of the greatest challenges to the substance abuse prevention field in Rhode Island, as well as nationally, continues to be the recruitment of new employees, and the retention of current ones, as our workforce ages into retirement or changes careers. BHDDH is dedicated to the recruitment, retention, education, and training of substance abuse treatment and prevention professionals and to improving the quality of our workforce. BHDDH collaborates with the

New England Addiction Technology Transfer Center (ATTC-NE), the New England Institute of Addiction Studies (NEIAS), the Rhode Island Prevention Resource Center (RIPRC), the Drug and Alcohol Treatment Association (DATA), the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for the Application of Prevention Technologies (CAPT) our state colleges and universities, and other community partners to develop and implement new initiatives to support workforce development.

BHDDH has finalized a prevention workforce development plan. The following are examples of activities we identified that would impact workforce development: identify prevention coaching opportunities between task force members; development of a manual for new staff; creating a professional development plan to include self-assessment. Self-assessment might be used as an individual's strategic plan. Self-assessment can promote individual responsibility and ownership of professional development, and it can be used to identify training and gaps.

RIPRC's Training and Technical Assistance (TTA) work plan and deliverables are based on the needs assessment data and will continue to focus on an environmental approach to prevention that captures substance use and abuse, but also works to reach the complementary goals of reducing the burden of mental, emotional, and behavioral disorders and promoting healthy development of children and young people in Rhode Island. The RIPRC has been a nice addition to the many long-standing, committed stakeholders led by BHDDH. BHDDH has an extensive number of prevention providers. (BHDDH requires funded providers to verify workforce development via the Rhode Island Certification Process and currently more than half of prevention providers are certified). The RIPRC has offered a certification preparation training and technical assistance to those providers in need of such assistance. We plan to develop a certification test preparation manual to provide further guidance and assistance. The comprehensive TTA is provided in the following five modalities: 1) Individualized/Organizational-specific TTA; 2) Learning Collaborative sessions (LC); 3) Content-specific Training; 4) riprc.org, a website for sharing resources and promoting training sessions; and 5) Collaboration with other TTA Providers.

Technical Assistance

The State continues to have additional opportunity for technical assistance through the Center for the Application of Prevention Technologies (CAPT) to develop service planning. Several needs have been identified. One need was for basic prevention training. The CAPT and RIPRC collaboratively delivered the Substance Abuse Prevention Skill Training and plan to offer it again at the New England School for Addiction Studies. Another identified need was to have the ability to repeatedly offer virtual learning and on particular content areas. The CAPT and RIPRC have offered worked together to offer ethics training on several occasions and will continue to offer this entry level training as well as an intermediate booster training in the coming year. We want to continue to build the capacity of the substance abuse prevention coalitions. The CAPT is currently cross walking the trainings that have been offered throughout Rhode Island and aligning them with the certification domains. This will be very helpful for our providers when they apply for certification. The CAPT organized several peer sharing calls to assist us in the implementation of an Evidence- Based Practices Workgroup by giving examples of how other states have achieved this function. The CAPT helped us to develop a logic model for our Student Assistance programs to administer Project Success. The CAPT has been very responsive in

offering technical assistance with emerging trends such as Naloxone. They are performing a literature review for ages 12-17 around the effectiveness of Naloxone and best practices within this age group.

Collaborations

The Governor's Council on Behavioral Health is the state's behavioral health planning council. Its purpose is to advise the Governor and General Assembly on policies, goals and operations of the behavioral health program, including areas of substance abuse and mental health, and on matters that BHDDH refers to the Council. It will be instrumental in the development and coordination of new prevention strategies. We recently developed a Prevention Advisory Committee (PAC) under the Governor's Council. The purpose of the Committee is to provide guidance to the Council regarding the planning and implementation of substance abuse prevention and mental health promotion services in the state. The goal of the Committee is to provide a forum to coordinate the State's strategic efforts to reduce the incidence and prevalence of alcohol, tobacco and other drug misuse and abuse as well as provide leadership and continuity in advancing prevention and mental health promotion for RI residents. The Committee also will assist the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals and the Governor's Council in attaining sustainable outcomes, reinforcing collaborative efforts, reducing redundancies, and aligning the state's resources to achieve objectives outlined in the RI Prevention Strategic Plan. The Evidence Based Practices Workgroup (EBPW) was created. The EBPW is a workgroup of the Prevention Advisory Committee (PAC) of the RI Governor's Council on Behavioral Health. The Evidence Based Practices Workgroup will provide guidance to the PAC and to the Council on use of evidence based practice in the delivery of behavioral healthcare services within Rhode Island. The workgroup membership was drawn from various behavioral health disciplines. The charge of the workgroup will be two-fold: One, develop guidelines for ascertaining whether a given practice, policy or program meets existing standards for evidence based practice in behavioral health; and two, identify a process by which an innovative or locally developed behavioral health practice, policy or program can be designated as an evidence based practice in RI.

BHDDH continues to have a collaborative relationship with the Rhode Island Department of Elementary and Secondary Education. Previously the Departments were partners on the Building State Capacity grant where we vetted our prevention strategic plan, which led to getting their approval and assistance in administering the Rhode Island Student Survey in several high schools and hope to conduct it more statewide in 2016. BHDDH works closely with the Department of Health on both their Suicide Prevention Subcommittee and Youth Risk Survey. Both Education and Health serve as members of the State Epidemiological Outcomes Workgroup. Furthermore, the University of Rhode Island Department of Psychology Community Research and Services Team (CRST) provides technical assistance and expert consultation to BHDDH and programs funded by BHDDH regarding process and outcome evaluation. This past winter the CAPT and BHDDH agreed on the next year's work plan which will focus on

Strategic Prevention Framework Partnerships For Success II

Rhode Island has received funding for the Strategic Prevention Framework Partnerships for Success (SPF-PFS) grant. This project is enhancing our current underage drinking efforts with youth ages 12-17. Our additional priorities are to reduce marijuana use among youth 12-17 and assess prescription drug use and misuse among youth and young adults ages 12-25 and the resultant burden.

Sub recipients have been funded in twelve Rhode Island communities of high need. These twelve sub-recipient communities comprise a large percentage of the state's population, and BHDDH anticipates state-wide reductions in the use of these substances. Sub-recipients are in the early stages of developing individualized strategic plans to address their target population.

The State continues the work of the State Epidemiological Outcomes Workgroup (SEOW) to institutionalize data-driven decision making for state and community level prevention planning and to integrate behavioral health indicators such as preventing mental illness and promoting positive mental health as it relates to substance abuse. This initiative will also address the need to assess and learn how State Epidemiologic and Outcome Workgroups have influenced state and community prevention planning.

This five-year proposal seeks to continue and extend work that has been conducted in partnership between Brown University, University of Rhode Island, JSI/Prevention Resource Center (PRC) and the State of Rhode Island.

Evaluation and Reporting.

The Universal intervention(s) programs will participate in a third-party evaluation (an ongoing requirement for primary prevention services providers) conducted by the Community Research and Services Team (CRST) of the University of Rhode Island Dept. of Psychology. (CRST is the SSA's prevention evaluation partner; it was the evaluator for the state's SPF SIG grant and is the evaluator for programs funded through the Governor's set-aside of the Safe and Drug Free Schools and Communities formula grant and programs funded through the SAPTBG as well as the SPF PFS.)

All primary prevention providers, regardless of funding source, are required to enter information into a Performance Based Prevention System (PBPS), a prevention management information system maintained by Mosaix through a contract with the Department. The PBPS has separate modules for community/school-based providers, Student Assistant Programs, and community task forces/coalitions. An evidence programming fidelity checklist and report that the Reducing Marijuana and Other Drug Initiative has been developed and providers submit this quarterly. A new prevention data collection and reporting system IMPACT, is being developed, which will be piloted within the SPF PFS sub recipients and rolled out to all prevention providers FY16. This will capture strategic plans which will include their long and short term outcomes as well as attainment and progress. This enhanced data collection will further assist CRST in their evaluation. Reporting will continue to be required for all prevention providers.

Data Collection and Analysis

All prevention programs are required to, and will continue to be required to, report service information into the state's prevention management information system PBPS. These data are used to generate routine reports on service delivery and participants. A new prevention data

collection and reporting system called IMPACT which is maintained by Mosaix has been developed. This system will capture relative information on the six CSAP Strategies, IOM Categories and overall will be a more comprehensive data collection system. IMPACT will be piloted with the Partnership for Success

Environmental Strategies

The major priority of the SSA in the area of environmental strategies was reducing youth access to alcohol and youth marijuana use, and continued to be funded by non-SAPTBG dollars. In addition, the SSA is engaged in capacity building efforts to increase the use of environmental strategies to prevent prescription drug misuse. Mothers Against Drunk Driving (MADD) and the Department of Transportation (DOT) will assist the SSA in conducting the annual Alcohol Purchase Survey to determine compliance with the state statute on alcohol sales to underage persons. This program continues to educate the public about laws to help reduce youth access to alcohol (e.g. procurement of alcohol for a minor by an adult). Environmental Strategies in RISAPA.

Rhode Island Substance Abuse Prevention Act (RISAPA) task force coalitions promote comprehensive environmental strategies at the community level. These coalitions implement social norms and communications campaigns documenting the norms of underage drinking and marijuana usage. Communities partner with local police departments and business owners to ensure effective enforcement efforts are implemented of local underage regulations. They track retail selling and serving to minors to ensure proper penalties are issued. Media advocacy is implemented to advance knowledge of social host laws. Prevention coordinators increase their efforts to establish local drop sites for unused medication. RISAPA also promotes the establishment of drug use policies in schools.

In Rhode Island, suicide is the third leading cause of injury death. In 2013, there were double the number of deaths due to suicide (136) in Rhode Island than due to car crashes (65), and four times the number of suicides as homicides (33). The number of suicides has increased each year in Rhode Island during 2004-2014, making suicide one of the top four injury priorities identified in the 2013 Injury Prevention Plan. The Rhode Island Violent Death Reporting System (RIVDRS) shows that from 2004 through 2014, 1062 Rhode Island adults died by suicide, approximately 104 each year. Adults aged 45-64 and men accounted for most of these deaths (43% and 80% respectively). Three hundred and fifty-five persons took their own life in Rhode Island during 2012-2014 and 3047 were seen in a hospital emergency room for a suicide attempt from 2012-2014. These findings have important implications for state suicide prevention efforts.

The most common circumstance recorded for adults who died by suicide was having a current mental health problem and the majority of them were receiving treatment (84%). Most suicide decedents had mental distress with multiple stresses (e.g. a recent crisis, physical health/job/financial problems) preceding death. These additional stresses may contribute to mental health treatment non-compliance. RIVDRS data suggests that mental health treatment alone might not sufficiently address all of the circumstances that contribute to suicide. A range of social supports are also needed to prevent suicide.

The Rhode Island Department of Health (DOH) has a federal grant to fund the Rhode Island Suicide Prevention Project. This program is implementing gatekeeper education programs in schools for faculty and staff, while providing suicide specific screening and triage protocols for school crisis teams to utilize. School crisis teams will have hotline access to timely evaluation and assessment services of youth and young adults at a mental health treatment hospital, as well as referral resources for federally qualified health centers, community mental health centers, and localized resources. The grant will also utilize a media campaign designed to help adults and adult parents of youth at risk for suicide to take action to limit access to lethal means within the home. The project currently operates in three of Rhode Island's core cities as defined by the U.S. Census, as well as other selected cities and towns with the potential to be a statewide program by 2019. BHDDH has a collaborative relationship with the Department of Health (DOH) and sits on the Suicide Prevention Subcommittee. The grant will expand the target population to include veterans and military families including activity duty stations, National Guard, and VA and Vet Center services. The program will provide focus on supporting LGBTQ youth, as well as working with suicide survivor support groups. The program intends to collaborate on research and data opportunities as they arise, including NIH, NIMH, CDC, HRSA, and SAMHSA projects as they arise in support of the research agenda release by the National Action Alliance for Suicide Prevention.

The data evaluation plan will include the number of youth identified by gatekeepers, screening, and referrals for mental health services. It will also include timely follow up care coordination for those who choose to enroll in the project specific follow up service which would include 2 week, 3 month, and one year follow up phone calls to assure access to care, reduce recidivism, and reduce barriers to care. The continued use of the Signs of Suicide program (SOS) youth gatekeeper education program will be offered in selected school districts to include programming for grades 7, 9, and 12, with additional focus for transition age youth. The project has also partnered with many local colleges and universities in support of their suicide prevention programming, and assisting with grant applications as requested.

Capacity to Address the Needs of Diverse Minorities and Native Americans

The Department has identified the need to reassess and develop a Disparity plan. BHDDH is partnering with the ATTC to develop this plan and ensure we are developing culturally sensitive and appropriate programs that will address mental health and substance use issues across cultures and ethnic groups represented throughout the state.

Data from 2010 Census identified Rhode Island as the state with the second smallest population-growth rate in the nation, with population change of only .4% from 2000 to 2010. Although this state-wide population growth was minimal, the racial-ethnic composition of Rhode Island changed, such that between 2000 and 2010, Hispanic and non-Hispanic black population increased from 8.7% to 12.4%, and from 4.8% to 6.2%, respectively.

With a growing minority population, there is a need in our core cities for more Spanish-language services and for more effective ways to engage Southeast Asian individuals. Between 2009 and 2011, 65% of children who lived in poverty were minorities (U.S. Census). Minority individuals are over-represented in both systems by comparison with their numbers in the community. There is also evidence from the

juvenile justice system that minority youth whose criminal behavior derives from behavioral disorders is far more likely to be incarcerated than their white counterparts, who are more typically diverted to behavioral health treatment.

The 2013 Youth Risk Behavior Survey indicates that 10.2% of Rhode Island's 16-17 year olds identify as lesbian, gay, bi-sexual or transgendered (LGBT). The 2013 Behavioral Risk Factor Surveillance System revealed that 7.3% of Rhode Island's 18-25 year olds identify as LGBT. The adult behavioral health MIS system does not track sexual preference, so we do not know how many of those being served are GLBT. Anecdotal information from the homeless system suggests that a disproportionate number of homeless youth (between 20% - 40%) are LGBT; in fact, it is estimated that between 20-40% of homeless youth are LGBT. There is a significant correlation between homelessness and mental health issues; an estimated 20-25% of homeless individuals have a serious mental illness.

BHDDH regulations require that behavioral health organizations have a written cultural diversity plan that addresses:

- The recruitment and retention of personnel who reflect the cultural diversity of the communities in which the CMHC provides services.
- A provision for recruiting leadership that is culturally representative of the individuals served by the organization.
- The availability of staff or interpreters to address the communication needs of persons served.

Minority individuals tend to live in core urban areas of the state, and the CMHCs and CMHCs in these areas make efforts to hire culturally and linguistically diverse staff. BHDDH currently contracts with one minority CMHC, the Minority Alcohol Program. In addition, The Providence Center has developed a Latino Health Home, which serves 200 SPMI and SMI consumers. All the team members are bi-lingual. Although it is based in Providence, it accepts referrals from other communities.

As will be described in Environmental Factors section 8, Rhode Island's only federally recognized tribe, the Narragansett has preferred to utilize state behavioral health services on an as-needed basis, rather than to engage in ongoing collaboration. Many tribal members get their health services through the Narragansett Indian Health Center. Native Americans typically make up 1% or less of public behavioral health consumers, which is consistent with the percentage of Native Americans in the state.

General Strengths and Needs of the System

Rhode Island's behavioral health service system has a number of strengths. These include:

- The state's commitment to the comprehensive reform effort described in the introduction, which is working to develop a behavioral system continuum of care imbedded in the state's healthcare system
- The close collaboration between the EOHHS departments, which allows for an interdepartmental approach to the changes in the behavioral healthcare system. Examples of these collaborations include the joint BHDDH/DCYF administration of the "Healthy

Transitions” grant, the BHDDH/DOH response to the overdose epidemic, the joint BHDDH/Department of Corrections re-entry grant application and pilot programs and the ongoing consultation between BHDDH and the Medicaid Authority as behavioral healthcare services move into managed care.

- The integration within BHDDH between substance abuse treatment, prevention and mental health services
- The integration within the peer and clinical training programs that address Mental Health, Substance use and prevention by all.
- The integration of the recovery model and recovery services into BHDDH’s system. This is described in Environmental Factors section 17
- The use of federal discretionary grants (listed above) to advance the goals of BHDDH and DCYF.
- The many innovative programs undertaken by CMHCs and other community service agencies that are outside of the framework of state contracts. Examples include The Kent Center’s designation as a Trauma Informed Provider, The Providence Center’s development of a Hispanic (behavioral) Health Home and Riverwood Mental Health Center’s development of the state’s first Housing First program.

At the same time, the state’s behavioral health system has a number of needs. These, which were identified by BHDDH, DCYF and the Governor’s Council on Behavioral Health, include:

- A robust data analysis capacity that can provide information on statewide needs, performance and service outcomes across departmental lines
- A more nimble purchasing and contracting capacity that will enable us to respond better to grant opportunities
- More state and other funding to enable us to expand and sustain best practices. Programs and services that start as pilots, usually using federal grant funds, are difficult to bring to scale or maintain without state funds and/or support from Medicaid and private insurers. EBPs initiated by DCYF, for example, have not been maintained to fidelity because of MCOs funding practices.
- The need for BHDDH, DCYF and other state departments to collaborate on training, policies and procedures for issues including cultural competency and diversity.
- Services to youth/young adults with behavioral health conditions
- More parent support programs
- Expansion of student assistance programs capacity for programs like SBIRT
- Services for veterans who do not have Tri-Care eligibility
- Behavioral Healthcare workforce development
- Reduce the number of opioid and prescription drug overdoses.

Planning Steps

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

Narrative Question:

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

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

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

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

Through the [Healthy People Initiative](#)¹⁸ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁸ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

Step 2 Needs Assessments

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

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

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Introduction:

Two separate planning processes to identify unmet behavioral healthcare system needs have taken place over the last few years in addition to the needs assessments undertaken by BHDDH and DCYF for this Block Grant Application.

As stated in Step 1, the Executive Office of Health and Human Services (EOHHS) solicited a study of the behavioral healthcare system in Rhode Island. The Truven Study (The "Rhode Island Behavioral Health Project," Truven Health Analytics, August 2015) is currently in draft form, however, as the document is finalized, the lead representatives from EOHHS and BHDDH provided the planning team with an overview of the concepts and findings. The study, which draws on data from NSCH, NSDUH, HCUP, CDC, PRAMS and Rhode Island agencies, is promoting a population health approach to allow the state to look at points across the life span and addressing critical points to intervene within the development process.

Highlights of the draft report comparing RI to the other New England states, include:

- ✓ Children in Rhode Island are at a greater risk for mental health and substance use disorders. The study suggests the state invest in proven, effective and preventative practices for children and families. Some of the risk factors include unemployment rates among parents, single parent households, inconsistent insurance coverage and poverty (1 in 5 children in RI live in poverty).

- ✓ High risk factors in childhood turn into high prevalence rates in adulthood. Adults in RI have higher rates of drug abuse and dependency and serious psychiatric distress.
- ✓ RI needs to shift from financing high cost reactive inpatient services towards person centered, community based, and recovery oriented, coordinated care.
- ✓ RI needs to coordinate data collection, reporting of outcome measures and analysis across departments.
- ✓ RI spends a substantial amount of money on behavioral health services, however, Rhode Islanders report unmet behavioral health needs. The state spends most of its dollars on inpatient services with no follow up upon release and prescription drugs. The state needs to invest more dollars on services that keep people in the community. The state ranks 29th per capita on community services across the country.
- ✓ The state has not had ACT programs since 2011, which leads to higher rates of homelessness, with only 2.6 percent of individuals with SPMI in supportive housing.
- ✓ Shortage of mental health and substance use disorder professionals. The state has increased prevalence rates and a shortage of professionals. Also, the state has the lowest percentage per capita of mental health agencies with specialized veterans' programs.
- ✓ Rhode Island adults show higher narcotic overdose rates.
- ✓ The state is in need of additional residential programs.
- ✓ Rhode Island needs to invest in community based programs and integrate them into other insurance programs.
- ✓ Young adults ages 18-25 are at greater risk of psychotic distress.
- ✓ Adults ages 26-64 have higher rates of drug dependency, mental illness, alcohol dependency and marijuana use and higher death rates.
- ✓ Older adults over the ages of 65 have higher rates of inpatient hospitalizations and institutionalizations.
- ✓ The state needs to invest in prevention and early intervention and shift to evidence based and promising practices, care coordination and population based measures.

In addition to the system-wide assessment of the Truven study, The Governor's Council on Behavioral Health developed its set of recommendations for future uses of the Block Grants. Below are the priorities, in order of their importance:

- Services Transitional age youth (ages 16-25)
- Capacity for needs assessment, performance and outcome data analysis
- Parent support programs
- Supplemental funding for children's EBP services that are not fully covered by insurers, including Medicaid MCOs
- Expansion of student assistance program capacity for interventions like SBIRT
- Services for veterans who are not eligible for Tri-Care
- Peer support services
- Behavioral healthcare workforce development
- Respite services
- Adolescent suicide prevention
- Anchor Recovery Centers

The first three priorities received far more Council member votes than the remaining items.

Unmet Needs and Critical Gaps within Rhode Island’s Service System: The following gaps analyses and plans were undertaken by DCYF and BHDDH for the Block Grant priority populations:

1. Comprehensive community-based mental health services for adults with SMI and children with SED

a. Children with SED and their families

1. Building the needed infrastructure for system changes: DCYF has been committed to building a system of care to provide services to the children, youth and families in Rhode Island in the least restrictive setting and in their community to address the high number of children and youth in out of home placement. The Family Care Community Partnerships and Family Care Networks were implemented to reflect this major re-envisioning of service provision in Rhode Island based on the values of a system of care of being family driven, youth guided, cultural competent system with ready access to quality services by child and family competent providers.

Unmet needs or GAP: A continued need exists for strengthening collaborations and data analysis among state departments, community agencies and health plans serving youth struggling with SED or substance use. A need also exists for re-examining current policy on a statewide level to ensure consistency in support for youth with SED or substance use challenges.

What DCYF is doing to address: To plan and build the system of care, DCYF established many collaborative agreements, projects, activities with various community organizations, businesses and local and state organizations. DCYF secured grant funding for building and implementing the SOC infrastructure through the SAMHSA Expansion Planning grant and the Expansion Implementation Cooperative Agreement. A strategic Blueprint was developed by a team inclusive of families of children and youth with SED, youth, family run organizations, diverse grassroots organizations, and administrators with decision-making power from the Department of Children, Youth and Families, RI Department of Education, RI Department of Health, RI Department of Behavioral Health, Developmental Disabilities, and Hospitals, and the Executive Office of Health and Human Services, the lead Medicaid authority in the state.

The goals of the SAMHSA Expansion Implementation Cooperative Agreement are to develop cross-agency infrastructure with the capacity to coordinate the SOC for children and youth with SED and their families, to develop and sustain a comprehensive array of mental health and recovery support services, to be driven and guided by the diverse population served and to increase support for system development among all parties

DCYF continues to work with various other state departments and community organizations to develop a continuum of services for children, youth and families regardless of whether they are open to DCYF or not. DCYF through funding from the Rhode Island Child Welfare-Early Care Partnership (2012) developed “an infrastructure across early care systems to ensure that infants and young children in the child welfare system receive quality early care and education services

that ameliorate the effects of exposure to trauma and improve their social emotional well-being to better address barriers to permanency.”

2. High number of children and youth in out of home placement: Over the past 10 years, DCYF has made significant progress on reducing the high number of children and youth in out of home placement. Even with these reductions, RI DCYF, in 2012, had almost twice the percentage (28%) of children in care as the national average (15%) as reported by The Annie E. Casey Foundation in May 20, 2014. DCYF also has a larger percentage of children age 13 and above (46%) as compared to the national average (34%). DCYF does have combined responsibility for addressing child welfare, juvenile justice and children’s mental health. The most prevalent reason children/youth age 13 and above are placed in an out of home setting is child/youth behavior.

There have been a number of different strategies over the past 10 years to reduce the number of children and youth in out of home placement. DCYF has done extensive worked on the system of care and development of community based services and Wraparound. At the same time, DCYF has been focusing on strategies that improve the services within the congregate care settings to ensure that youth are receiving the appropriate level of care and for the appropriate length of time within the setting, reducing the utilization of psychotropic medications; and, ensuring that effective aftercare supports and services are available to transition the child back home. DCYF is focused in two distinct areas:

- Slowing the entry of children into our system, and;
- Moving those in our system into a reunification or permanency situation more efficiently.

The following table shows the reduction in residential placement over the past 5 years and the increase in FY 2014 of the number of residential placements both in state and out of state. A further increase is projected for FY 2015. In FY 2014 there was also an increase in the number of maltreatment reports and completed investigation by over 600 each for the year. There has also been an increase in admissions, readmissions and length of stay in psychiatric facilities due to lack of available and appropriate step down programs in the community.

Period	Daily Residential Placement average daily	Out of State Placement average daily	Average daily residential including medical and psychiatric hospital	Average daily foster care census	Daily Psychiatric Hospitalization census (as of June 30th of each year)
<i>FY 2011</i>	686	50	809	1183	
<i>FY 2012</i>	549	46	652	1101	24
<i>FY 2013</i>	507	42	615	1078	32
<i>FY 2014</i>	520	71	616	1144	55

FY 2015	525	82	635	1234	39
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The average daily residential placement numbers are based on a point in time averaged over 12 months and includes medical and psychiatric hospital stays.

The intent of Family Care Network (FCN) was to assist in reducing the number of youth in congregate care setting and to increase the use of community-based and evidence based services. The CANS (Child and Adolescent Needs and Strengths), a nationally validated, evidence-based, standardized assessment tool that supports effective service planning and decision-making has been implemented for all children and youth in congregate care settings. Other activities and initiatives include focusing on training and implementation of trauma-informed and trauma services in all aspects of work with children, youth and families and increasing the number of evidence-based programs and services available for children and youth who are in the community and are in congregate care and transitioning back home.

Unmet Service Needs: Despite the development of new resources and the efforts of implementing a major system change and a paradigm shift amongst the various stakeholders within the SOC, the goal of reducing the number of children and youth in congregate care has not been realized.

How DCYF will meet these needs: DCYF is in the process of reviewing the progress and challenges of redefining and restructuring its service delivery system to meet the needs of children, youth and families within a quality cost effective system of care. DCYF has developed a five year Title IV-B Child and Family Service Plan for the department. Two of the objectives from this plan specifically address strategies and activities that: reduce the need for congregate care with greater emphasis on prevention-focused services and supports and increase the resource capacity of family homes to decrease the number of placement disruptions and use of congregate care.

In addition, DCYF is undergoing a major overhaul with a new governor and executive team taking a critical look at how DCYF services are purchased and provided. With the help of the Harvard Government Performance Lab, Annie E. Casey, and Casey Family Programs, DCYF is in the process of re-envisioning the services provided compared to the needs and determine how to provide those services – whether internally or through external agencies. Should any services require procurement, DCYF shall work with the State Division of Purchasing to develop and issue a RFP for competitive bid. Should the procurement process take longer than expected, the Department may consider extending existing contracts for a limited time.

DCYF’s continues to focus on maintaining children safely in their homes with supportive home and community-based services. Much of this emphasis is focused on the front-end of DCYF’s service system – helping child protection investigators to work more diligently with families and community providers to avert families from being opened to the DCYF wherever possible and appropriate. DCYF continues to recognize the importance of ensuring children and families are systematically assessed at their initial contact with the Department. Starting in May 2015, DCYF has been collaborating with Annie E. Casey to review Structured Decision Making (SDM) as a potential practice model. In June 2015, Annie E. Casey and the Structured Decision Making team presented to DCYF on SDM and the benefits associated with a uniform assessment system

for families upon initial contact with the Department, with an emphasis in the Child Protection Service unit. The Department continues to explore SDM and will make a decision in FY16.

DCYF is also exploring the use of some additional tools and processes that have been successful in other states. These include Team Decision Making, Differential Response, Expedited Permanency Meetings, Coaching for Child Welfare Supervisors.

3. Need for Peer Support Services as part of service array: DCYF has supported a fully independent family organization that received funding through state appropriations to assist in infrastructure development, as well as providing direct support to family and youth. Family organizations provide peer support and mentoring to help families improve skills, knowledge and self-efficacy so they will be able to navigate the child/family service system more effectively.

Unmet Service Needs: Family peer support is available through the FCCP and some community agencies but is limited in part because there is no permanent funding source in RI for peer support services. There has been much work on a state wide bases to have peer support services be billable through Medicaid and a training program has been instituted. Having peer supports has been shown to be helpful to other family members including youth support peer. Peer support is needed when families are in crisis and struggling with issues such as poverty, homelessness, mental health, and substance abuse of parents or children. Parents could benefit from peer support, education and assistance in negotiating a system of care for which they are not familiar. This type of service provision (peer support) is very helpful to parents so that they can learn and be supported in the decision making process to address the presenting challenges instead of being opened to DCYF.

How DCYF will meet these needs: DCYF will continue to provide support for family peer support. Through analyzing data collected in RIFIS, DCYF has been able to show evidence that families receiving services from the FCCPs have improved functioning when they have the support and assistance of Family Support Partners. Due to the availability of this RIFIS data, the DCYF has been able to justify moving forward with planning for increasing the numbers of Family Support Partners. DCYF has been able to show the effectiveness of involving peer support for families through family support community organizations in the wraparound family team meetings. The Rhode Island Family Information System (RIFIS) provides a means of collecting additional information for looking at outcomes and providing services to those families involved with the FCCPs who have children diagnosed with SED.

4. Development of community based and evidence based services: The DCYF system of care transformation has required the development of a robust continuum of services that can effectively meet the needs of children, youth and families in a community setting. At the core of DCYF's efforts to realize such a system is the development and implementation of evidence based and promising practices for addressing the needs of children and their families. DCYF has been working closely with the Executive Office of Health and Human Services, Neighborhood Health Plan/Beacon, and community providers to make these services available. Current EBPs that are available include, but are not limited to, Multi-Systemic Therapy, Parenting with Love and Limits, Alternatives for Families – Cognitive Behavioral Therapy, Triple P, and

Strengthening Families, with others in various stages of implementation. This array of EBPs provides the following:

- Places a greater focus on prevention and early intervention programs, instead of waiting to intervene until after problems occur. The benefit: addressing root causes head on as early as possible.
- Invests in proven programs that have a track record of benefiting children and families and make them available for every eligible child. Not only are these programs proven to work, they are also matched to the neighborhood's strengths and needs.
- Creates strong partnerships among public systems and schools and the families and communities they serve.

Unmet Service Needs: Much attention has been given to identifying the best evidence based practices for a variety of issues and problem areas. Even after identifying the best evidence based practices, the initial cost in time and money of obtaining the rights to use the program, the training, supervision and cost of materials, and then the advertising and recruitment of participants and the ongoing funding mechanism need to be addressed. All these requirements to start an evidence based practices are significant. Some organizations have received seed money to start evidence based programs, but there is a sizable need for additional seed money to develop and implement those evidence based practices that have been found to be effective in meeting the specific needs of children. Moreover, some EBPs have been approved for payment through health insurance or Medicaid but this funding does not cover all the cost of the programs. And some EBP's do not meet the requirements for funding through insurance or Medicaid and must be paid by other funding sources.

There are still not enough community based programming and there is underuse of new evidence based and community programs based on not trusting that these programs can provide the services needed by the child/youth/family.

How DCYF will meet these needs: DCYF will continue to develop and utilize a continuum of care that includes an expansion of evidence based services. In selecting new programs and services, DCYF will adhere to procurement procedures that require proposals to be submitted through a Request for Proposals (RFP) process. An internal review body within DCYF is comprised of representatives from Child Welfare, Juvenile Corrections, Children's Behavioral Health, and Management and Budget. This body reviews and scores proposals and recommends the selection(s) to the Department Director for finalization.

DCYF was awarded a title IV-E Waiver. The focus of this demonstration project is: Reducing Reliance on Congregate Care and Increasing Community-Based Service Supports for Children and Families. In order to move forward and continue the previous decrease in use and reliance on residential treatment, a greater diversity and availability of intensive community based and evidence based services need to be available to meet the individual needs of children and families and access to those services needs to be improved statewide.

DCYF's strategy is to develop and expand the use of community based and evidence based practices that focus on working with the family and child/youth in the community to prevent

removal. Mobile crisis response is an example of the type of service that DCYF would like to make more widely available, as this has proven effective in preventing hospitalization and long-stays in residential programs for children at risk of SED and those already diagnosed with SED.

Another strategy is to expand and increase the array of community-based services to support reunification, shorten the length of stay in out of home placement and prevent re-entries into care. These activities include focusing on training congregate care staff on providing trauma-focused care.

5. Limited resources for data analysis and data-based planning: DCYF has two main MIS systems, RICHIST for children and families open to DCYF, and RIFIS for children families receiving services through the FCCP and not open to DCYF. RICHIST continues to be a valuable information tool to DCYF. RICHIST has maintained the ability to track and identify the status, demographics, location and service plan goal for the placement of children in foster care. The location of a child's whereabouts is recorded in RICHIST regardless of whether the child is in a paid, unpaid, unlicensed, or voluntary placement.

Yale has provided much of DCYF's data analysis and comprehensive reports on data both in RICHIST and RIFIS. In addition, results from the CANS and other functional assessments are collected in the EOHHS Community Supports Management module of the Human Service Data Warehouse. Data is now available on children in placement and initial reports show areas of need through the use of the CANS but further development and analysis is needed.

Critical Gap: Since DCYF uses two different MIS systems (RICHIST and RIFIS) for collecting client specific data, it is difficult and time consuming to produce reports that analyze the effectiveness of wraparound services, and specifically whether the preventive, diversionary process is working to support families who are at risk for DCYF involvement and whose children who are mentally, emotionally and behaviorally challenged to prevent placement and hospitalization. Limitations of RICHIST are due to the fact that it is a 17 year old system and while it currently supports the functional requirements of the department (tracking placements, service plans, costs, demographics, outcomes, etc.), it is limited in its ability to support a mobile, field-based workforce.

How DCYF will meet this gap: DCYF has reviewed and coordinated presentations by external vendors (some of which was in collaboration with Annie E. Casey) on potential options to upgrade RICHIST and allow for web-based access and data entry by service providers. DCYF is working with the Executive Office of Health and Human Services (EOHHS) data warehouse to explore options for the EOHHS Data warehouse to produce dashboards with enhanced functionality such as data layering and turning on and off certain analysis parameters. Another option DCYF is exploring is upgrading SAS (statistical analysis software) graphing capabilities that would allow DCYF to produce graphs directly aligned with the DCYF's statistical analysis reports. DCYF anticipates this review process will continue with the aim of finalizing the decision in the fall of 2015.

b. Adults with SMI:

Rhode Island has the highest rate of mental health illness in adults in the country, with 24.2% of the population presenting with this issue. Rhode Island also has a high rate of serious mental health issues in adults (7.2%). According to the Truven Demand Study, Rhode Island has higher rates of serious psychological distress than the other New England states and the nation as a whole. It has a higher rate of adults 25 to 64 receiving mental health care in the past year (24% in 2011) than both the other New England states and the country (15%). Finally, it has a higher hospital admission rate for mental illness than the other New England states and the national as a whole for adults 18. At the same time, more Rhode Island Adults (7%) are likely to report unmet needs for behavioral health than are adults in the other New England states.

Unmet service needs: As noted above, the Truven Study indicates that Rhode Island, whose population has higher levels of psychological distress and utilization of mental health services, is overly reliant on psychiatric hospitalization and prescription medications. This dependence on what it characterizes as “high-cost, intensive and reactive services” has unsatisfactory results for consumers, while at the same time driving behavioral healthcare costs higher than in most other states. The \$853 million spent on behavioral health treatment in 2013 represented 1.6% of its Gross Domestic Product (GDP), as opposed to the national average of 1.2% of GDP.

The Truven report identifies the lack of investment in patient-centered, community-based, recovery-oriented, coordinated care using evidence-based services as the reason for the overuse of psychiatric hospital care. Among the problems cited:

- The end of Assertive Community Treatment in 2011
- The low rate of per capita spending on community services. Rhode Island rate 29th in the nation on this measure.
- The shortage of behavioral health and substance abuse counselors as compared to the other New England states.
- The lack of coordination between psychiatric hospital and community treatment. One in five Rhode Island Medicaid beneficiaries had no follow up mental health services following hospital discharge.
- The lack of affordable supportive housing services. Rhode Island’s mental health system has a higher rate of homelessness among its clients than the national average (5% versus 3.3%), yet only 2.6% of those with SMI served by the system received supportive housing.
- The lack of integration between community services and Medicare, Medicaid (both fee-for-service and MCO) and private insurers. Some best practices in community-based services are not fully funded or not funded at all by insurers.

What the Department is currently doing to meet these needs: The Department’s goal is to reduce unnecessary hospitalizations and emergency services admissions. This will be accomplished through incentive based contracting in our Health Homes as well as collaborating with the Division of Medicaid to ensure that the appropriate community-based services are available to ensure individuals are able to remain in the community. BHDDH manages a number of initiatives to address aspects of the need for more community treatment and recovery supports. These include:

- Behavioral Health Home services that provide case and care management, peer supports, health and wellness service and employment supports in addition to psychiatric and counseling services
- The continuing expansion of peer supports and recovery services (see “Recovery” Environmental Factor #17)
- The CSC EBP for first-episode of SMI in the Health Transitions
- The 811 program for permanent supportive housing and CABHI grant-funded housing retention services
- Outreach and engagement through the PATH grant
- Recovery supports through Medicaid
- Block-grant funded training for CBHO staff
- The person centered planning process in HCBS
- The mental health court diversion program training
- Specialized residential peer supports

Plans to address unmet needs: Rhode Island in the process of transforming its behavioral healthcare system through several initiatives that are focusing on integrating health and behavioral healthcare systems and creating, through our reinventing Medicaid legislation, new service packages that would provide housing retention, supportive employment and recovery services through Medicaid. The state will submit a request to CMS once all work plans for reinventing Medicaid have been vetted.

While this important planning process is taking place, BHDDH has a three pronged approach to address the needs of individuals with SMI.

1. Peer Supports: The Block Grant is providing funding for a comprehensive peer support system. BHDDH is in the midst of major advances with regard to Peer Recovery Services. Over the past eight years the Department focused on the development of peer services in Rhode Island, which included the initial training of substance abuse Recovery Coaches (2007), the first training of Peer Specialists to support people with mental illness (2012), the certification of mental health peer specialists by BHDDH (2012), the Rhode Island Certification Board’s development of a certification for Peer Recovery Specialists and the receipt of SAMHSA/BRSS TACS awards in 2014 and 2015. The current advances are mostly due to BRSS TACS and a new approach to funding for Mental Health Peer Recovery Services. Both are briefly described below.

BRSS TACS

BHDDH is currently leading a Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Academy project team. The focus of this project is to increase the availability of competent Peer Recovery Support Services and ensure adequate funding for Peer Recovery Support. The Rhode Island BRSS TACS team is composed of peers, behavioral health community leaders, providers, advocacy agencies, academicians and representatives from the RI Medicaid office, Department of Health and Certification Board. To date, the BRSS TACS team has accomplished the following:

- Completed a Behavioral Health Peer Recovery Specialist job description for Medicaid which part of an 1115 Medicaid Waiver application pending at EOHHS.
- Developed an integrated Mental Health/Substance Use Disorder Peer Recovery Specialist curriculum designed to be co-taught by mental health and substance use disorder peers. This curriculum will be piloted in June, 2015.
- Developed a questionnaire for measuring outcomes of an integrated peer recovery training and certification process
- Adopted an integrated Peer Recovery Specialist certification process, effective, 1/1/15. (Prior to BRSS TACS, Mental Health and Substance Use Disorder PRSs had different certification processes.)

By September 2015, RI BRSS TACS plans to implement data collection systems to better understand outcomes associated with:

- *consumers* seeking assistance from a peer recovery specialist and
- *peer recovery specialists* working within Rhode Island's recovery-oriented system of care for substance use and mental health services.

Funding for Mental Health Peer Recovery Services

BHDDH's current focus is on coordinating and strengthening the infrastructure and leadership for Mental Health Peer Recovery Services as well as providing assistance to mental health consumers in integrating into existing community services and activities.

This will be accomplished by:

- Providing and coordinating peer support services, education, and training
- Developing and conducting a mental health peer leadership training program
- Developing and implementing prototypes for essential tools and systems to professionalize the field of Peer Recovery Specialists
- Developing a plan for hiring Peer Recovery Specialists and subcontracting their services to Community Mental Health Centers and other agencies

2. **Supportive Housing Programs:** BHDDH recognizes that housing is a critical component in the lives of individuals with SMI. The goal of the Department is to provide housing opportunities in the least restrictive setting. The housing should also be integrated into the community and be affordable, meaning individuals pay no more than 30% of their income for rent. BHDDH has collaborated with the state's housing finance agency (HFA) on two grant programs. The first program is the Department of Housing and Urban Development's 811 program. This program provide 150 housing subsidies through the state's HFA for individuals who are experiencing chronic homelessness, BHDDH's population who would like to live in the community in supportive housing and individuals in the state's Money Follows the Person program. The state service departments (BHDDH and Medicaid) provide supportive services to ensure individuals can retain housing. The second grant that the Department applied for and received this summer is the Cooperative Agreement to Benefit Homeless Individuals. This program will provide treatment and recovery services and 150 new housing vouchers to individuals who are homeless and have mental health and substance use disorders. The program will also provide treatment and recovery support services to 150 individuals who are currently living in permanent supportive housing who have not traditionally had access to these services.

Housing Retention Services: BHDDH and other community based providers have been developing a Housing Retention Service package with the Division of Medicaid over the past several years. As stated previously, the housing retention service package has become a component of the Reinventing Medicaid legislative initiative and it is our hope that this package will be submitted to CMS for approval over the next 12 months. This package of services would provide a continuum of services that focus on housing retention and include care coordination, peer supports, daily living skills, case management, and supportive employment and recovery services.

3. **Performance based contracting:** BHDDH is also revising its contracts with the CMHOs to make them more accountable for overuse of hospital resources and to encourage them to develop better community-based alternatives to hospital use. There will be financial incentives in the new contracts to reduce the rate of use among Health Home clients of emergency departments and to reduce the number of readmissions into psychiatric hospital beds.

c. Older Adults with SMI

Needs and Service Gaps: As with adults with SMI in general, Rhode Island's elderly adults tend to be hospitalized and put into other intensive residential treatment for lack of a more robust community services capacity. The Truven Study notes, Rhode Island adults over age 65 are admitted to mental health and substance abuse facilities at a higher rate than the national average. Currently, roughly 80 percent of long-term care dollars are spent on elders and adults with disabilities in nursing homes, a third above the national average. BHDDH met with the Division of Elderly Affairs and EOHHS' "Money Follows the Person" team and held focus groups of the Rhode Island Coalition on Elder Mental Health and Addiction Coalition to explore this problem area. The gaps identified were:

- A lack of residential care that can accommodate individuals with SMI who do not require nursing home level of care
- A lack of home and community-based behavioral health care for individuals who are not CSP clients. This means that home-based specialized geriatric behavioral healthcare and case management are largely unavailable.
- A lack of geriatric expertise in most of the BHOs. State regulations do not require geriatric-specific services. Only one CMHO has staff specifically assigned to working with elders.
- The lack of capacity to deal with behavioral health issues among medical home health programs.
- A lack of continuity of care between hospital and community. There are wait times to get behavioral healthcare (which is usually office-based) post discharge and little case management to follow through on medication and other issues.
- Attitudes towards help-seeking, particularly around behavioral health, among elders.
- Under-recognized substance abuse problems among seniors.

Services that are currently being provided:

- The Division of Elderly Affairs contracts with CAPs to respond to emergency services for elders in their homes and follow up case management. This is a voluntary, non-emergency service. After hours, the state's 2-1-1 service provides phone response. In psychiatric emergencies, one of the CMHOs provides its in-person emergency response, which may be in the home.
- Home-based behavioral Health Home services are provided to the HH's clients.
- One of the two MCOs provides care management.
- BHDDH administers the state's PASSR program
- BHDDH participates in the Rhode Island Coalition for Elder Mental Health and Addictions (RIEMHAC), which includes homeless service providers, direct service providers, community action programs, the Department of Elderly Affairs, homeless service providers and the Money Follows the Person initiative to identify gaps in the system and develop appropriate community based services.
- BHDDH collaborates with the EOHHS

Plans to address the needs:

- Develop a plan to increase access to community-based behavioral healthcare and address service gaps in our system.
- Work with EOHHS Division of Medicaid to develop a housing retention service package that would be reimbursable through Medicaid. This initiative has been adopted as a "reinventing Medicaid" strategy and will be part of a package of services options sent to CMS for approval over the next 6 months. If this package is approved it will allow for the much needed clinical geriatric support needed to participate in community based teams working with older adults, increasing access to case management and other home-based services.
- Work with EOHHS/Medicaid to get MCOs to provide care management for elders.
- Adapt the Department's Peer Support initiative, which is funded through the Mental Health Block Grant, will also be a resource for older adults with SMI.
- Adapt the Department's training contract to enhance awareness and clinical skills around geriatric issues.
- Begin planning to require enhanced CMHO capacity for geriatric practice in the next contract cycle.
- Work with RIEMHAC and EOHHS on strategies to enhance basic awareness of geriatric behavioral health issues among home health programs

While a number of state agencies have collaborated over the last few years to solve elderly issues, there has not been a coordinated interagency effort dealing specifically with elder behavioral issues. Over the last six months, BHDDH has begun exploring the scope of the problems of elder individuals with behavioral problems with the Division of Elderly Affairs, EOHHS and the Rhode Island Elder Mental Health and Addictions Coalition, which includes the service providers for case management and emergency services to elders. More planning needs to be done to further understand and prioritize needs and to develop a joint action plan to address them. Therefore, the first year's strategy involves BHDDH taking the state lead in convening planning sessions and developing a state action plan for elders with behavioral problems.

d. Individuals with SMI or SED in the rural and homeless Populations

Homeless Adults w/Behavioral Disorders: According to the National Alliance on Homelessness, 2014 State of Homelessness Report, in January 2014 the national count found 578,424 persons experiencing homelessness (18 persons experiencing homelessness of every 10,000 persons in the general public). Persons experiencing chronic homelessness represent approximately 15% of the homeless population (84,291). Veterans represent 9% (49,933). Across the country in the last 5 years, the number of veterans experiencing homelessness was reduced by 33% and persons' experiencing chronic homeless was reduced by 30%. In Rhode Island, the January 2014 Point in Time Count found 204 chronic homeless persons and an additional 108 homeless veterans.¹

The Rhode Island Coalition for the Homeless administers the state's Homeless Management Information System (HMIS) and reported an 8.5% decrease in the overall numbers of homelessness from 4,447 to 4,067 in 2014. The decrease in overall homeless numbers can be attributed to a couple factors; 1) targeting available units for veterans and persons experiencing chronic homelessness and 2) families being diverted from the shelter system.²

In July, 2014, Rhode Island joined the Zero 2016 campaign, a national movement assisting communities to reach functional zero for the numbers of chronic homeless individuals and homeless veterans, and began using the Service Prioritization Decision Assistance Tool (SPDAT) assessment to identify the state's most vulnerable persons and prioritize them for housing. Volunteers and professionals performed the VI-SPDAT (a shorter version of the SPDAT meant to identify vulnerabilities) in late summer 2014 and March 2015. The following data was collected during these outreach efforts and represent the literally homeless persons who chose to participate in the surveys. Many had long term histories of homelessness. In addition they had reported drug and/or alcohol abuse or visiting the emergency room for mental health reasons.

The information below is based on 504 persons who participated in the VI-SPDAT:

- 71.3% are male and 28.7% are female;
- 95.4% were single and 4.6% married;
- 67.5% were White, 25.1% Black or African American and 3.2% were American Indian or Alaska Native; 14.5% were Hispanic or Latino;
- 10% were veterans.

- Over the past 6 months they reported:
 - ❖ being in the emergency room (100%);
 - ❖ having an interaction with the police (100%);
 - ❖ being taken to the hospital by ambulance (100%);

¹ National Alliance to End Homeless, State of Homelessness Report 2014, www.naeh.org

² RI Homeless Management Information System

- ❖ inpatient hospitalization, including for mental health reasons (100%);
- ❖ had a problem with drugs and alcohol (86%);
- ❖ treatment for alcohol and drug problems and returned to using (63%);
- ❖ being taken to the hospital for mental health reasons against their will (31%);
- ❖ going to the emergency room because they were not feeling emotionally well (64%)
- ❖ speaking with a mental health professional or a psychiatrist (64%)
- ❖ having problems concentrating or with memory (66%)
- ❖ emotional, physical, psychological, sexual or other abuse or trauma³(54%)

Unmet need: There is a need for affordable housing with supportive services that focus on housing retention. There is also a need for additional programs at both ends of the housing continuum, Housing First and Sober Housing models. There is also a need for chronically homeless individuals to attain economic stability. Finally, there is a great need among chronically homeless individuals to have behavioral health services that meet their particular needs.

What the state is doing to address the need: The state has committed to homeless outreach, Housing First and permanent supported housing as its strategy to reduce behavior disorders among the chronic homeless. This has been consistent in the design of the CABHI and PATH grants, staff's leadership on the CoC's Plan to End Homelessness and the Governor's Interagency Council on Homelessness. The State has established a permanent funding stream for housing vouchers for individuals and families experiencing long term homelessness. BHDDH is working with the Division of Medicaid to establish a Housing Retention/Stabilization service package that would be reimbursable by Medicaid. Key services that are needed by this population are not provided and/or funded by the current service system. Chief among them are the often long-term engagement services needed to bring alienated individuals to accept substance abuse services along with the medical, financial, employment and community services that they need for recovery. Case management and care management are equally important services that are typically not funded sufficiently to meet this group's needs. The use of peers to both engage and case manage chronically homeless individuals with substance use disorders is a promising practice that has had only limited use in Rhode Island. The state had requested that Medicaid allow for housing support services as part of its Medicaid Waiver previously and is preparing to submit this request again. It is our hope that the Center for Medicaid Services will act favorably upon this request.

BHDDH applied for and was awarded a Cooperative Agreement to Benefit Homeless Individuals (CABHI) grant through the SAMHSA this summer which will begin in the fall. This grant will provide the leverage to pilot and implement Housing Retention Services and provide permanent supportive housing, services and access to mainstream benefits through to SOAR to 300

³ RI Homeless Management Information System, VI-SPDAT surveys

individuals over 3 years. Key components to this program will be the peer specialist, who will have been certified and trained through the Peer Recover Support programs funded through the Block Grant.

The cost to the healthcare system of having chronically homeless, behavior disordered people go untreated became a major issue in 2012-2013. A legislative study estimated that Providence was spending \$1.3 million dollars annually transporting individuals with SMI/substance use disorders, most of them chronically homeless, to the city's emergency rooms. 160 individuals were admitted 2835 times, with 1109 of these admissions by just 11 individuals who were chronically inebriated/SMI. BHDDH was tasked by legislation to propose a pilot program to divert ED admissions and provide effective treatment for this population. The Department created the RESPECT program which leverages both mental health and substance abuse block grant dollars to prevent step down residential from the psychiatric hospitals as well as detox and a peer support emergency department diversion program.

In line with Rhode Island's and the nation's "Opening Doors" plans to end homelessness, the state has adopted a "Housing First" model, which sees housing as a necessary condition for treatment, rather than restricting housing to those who are already in treatment. For individuals, particularly among the chronically homeless, who have often been alienated for many years from mainstream treatment resources; this is often the only realistic approach. However, it requires that services be available to support treatment, recovery and housing retention. Key services that are needed by this population are not provided and/or funded by the current service system. Chief among them are the often long-term engagement services needed to bring alienated individuals to accept substance abuse services along with the medical, financial, employment and community services that they need for recovery. Case management and care management are equally important services that are typically not funded sufficiently to meet this group's needs. The use of peers to both engage and case manage chronically homeless substance abusers is a promising practice that has had only limited use in Rhode Island. The state has requested that Medicaid allow for housing support services as part of its Medicaid Waiver. The Center for Medicaid Services has not yet acted on this request.

The action plan proposed in this Block Grant Application addresses three needs of chronically homeless individuals with SMI and other behavior disorders. The first is the need for permanent supportive housing, which will be greatly increased by the state's new CABHI grant. The second is for economic stability, which will be aided by SOAR. The third is for more intensive behavioral health services, which will be addressed by the introduction of new CABHI housing support services and by requirements in the SFY 2016 PATH contract for more intensive community-based services to homeless individuals.

2. Services for persons with or at risk of having substance abuse and/or SMI/SED

Introduction:

The Truven Study notes some broad indicators of Rhode Island's problems with substance abuse. It notes that the state has the 7th highest rate in the nation for illicit substance use by young adults

and adult dependence or abuse of illicit drugs and of deaths attributed to narcotics or hallucinogens.

The most recent (2013) NSDUH consumption data indicates that Rhode Island continues to be below the national average for underage alcohol and tobacco use, although it continues to exceed the national rate for past month marijuana use. Alcohol abuse and dependence across all age groups has continued to exceed the national average since 2004, although it is dropping along with the national rate. Underage prescription drug use continues to be below the national average. Drug abuse or dependence across all ages has continued to exceed the national average since 2004. Past month use of alcohol, marijuana and illicit drugs has remained higher than the national average across all age groups since 2004. Non-medical use of pain relievers has also remained above the national average for all age groups since 2004. The percentage of people needing but not receiving drug treatment has surpassed the national average across all age groups since 2004. Similarly, the percentage of Rhode Islanders needing but not receiving alcohol treatment has continue to surpass the national average across all age groups since 2004.

Both the NSDUH data and the Truven study describe a state with high levels of drug and alcohol use and overall insufficient availability of treatment services.

By increasing capacity and access to treatment and recovery support services, Rhode Island will reduce the number of deaths related to substance misuse; decrease the prevalence of substance use disorders; increase abstinence rates; decrease overutilization of costly healthcare services such as emergency department visits and hospitalizations; reduce alcohol consumption and use of opioid medications; reduce crime related to substance misuse and improve overall health outcomes. The Department will continue to focus on:

- Monitoring compliance of the state's BHOs with state regulations and contracts
- Enhancing the use of peer supports by supporting peer training and certification and by using peer support staff to address the most pressing substance abuse treatment needs. For example, recovery coaches currently engage with overdose survivors starting with first contact at hospital emergency rooms and continue to support them to seek treatment and recovery services. Starting this fiscal year, these peers will extend their work to drug activity "hot spots" in the state.
- Providing adequate levels of residential treatment, detox and step-down
- Supporting Medication Assisted Treatment Health Homes
- Support and monitor a certification process for recovery housing
- Continue accessing trends and provide educational trainings regarding the best evidence based practices.

Within this context, the Block Grant priority populations' needs are as follows:

a. Persons who are intravenous drug users:

1. Overdose deaths from illicit drugs.

Unmet need: Sufficient services to prevent overdose deaths

Problem description and Data: Rhode Island continues to be among the states with the highest overdose death rates in the nation. In 2014, 239 individuals in Rhode Island died as a result of

accidental overdoses, 90% of which were caused by opioids. A high percentage of these deaths (37%) were the result of fentanyl-laced heroin. Associated with the overdose “epidemic” are the facts that funded treatment slots are consistently filled to capacity and that fact that most overdose survivors leave hospital emergency departments and inpatient care with minimal follow up. Often, emergency departments can provide little in the way of assessment or early intervention.

What the Department is doing to meet this need? BHDDH provides a number of approaches to reducing opioid overdoses. These include:

- Peers services funded by the Block Grant supported “Respect” program (see below)
- Medication Assisted Treatment (see description in Environmental Factor section 15)
- Step-down and detoxification services. The Department added regulations for all licensed treatment facilities to assess for appropriate ASAM level of care placement and then reviews implementation during audits
- Naloxone distribution in collaboration with the Department of Health, Department of Corrections, EMT’s and local and state police departments
- Participation of licensed BHOs in the state’s Prescription Drug Monitoring Program.
- Program participation in the “Current Care” information system which allows providers to share treatment information with each other for consenting patients
- Support Community Recovery Centers and advocacy programs
- Initiated regulations that address mandatory instruction of Narcan use to all clients with an opioid use disorder or who are high risk.
- Support programs that train and supply Narcan to the community at large.
- The Department provide trainings in the community for prescribers to acquire CME’s on minimizing the risks in Prescription Prescribing.
- Provided six “Grand Rounds” training on various addiction topics to local Universities.
- Utilizes media and bill board support to target access to treatment referral support through the “Addiction is a Disease, Treatment is available and Recovery is possible” campaign.
- Sponsor and support annual *Rally4Recovery* event which has Narcan informational booths and personal sharing’s from individuals and family members on the joy of recovery.

Plan: BHDDH is working in tandem with the Department of Health to reduce opioid overdoses. The Department will contract with Brown University and Johns Hopkins University to analyze data and produce community strategies to intervene, including the identification of “hot spots” to focus outreach, engage and education. The Block Grant-funded “Respect” program will address IV drug use, opioid overdoses and other substance abuse-related problems by funding four activities:

Early intervention in emergency rooms by trained peers with individuals experiencing overdoses. The peers follow the individuals and support them in seeking treatment and recovery services.

This year, the peers will begin outreaching to IV drug users in “hot spot” areas of high drug use.

Using SATBG funds, BHDDH partnered with The Providence Center’s Anchor Recovery Center, Rhode Island’s peer recovery organization, to develop a peer-run intervention, AnchorED, in eight of the ten state’s hospital emergency departments and three walk-in Urgent care’s.

BHDDH and the Anchor Recovery Center developed a program specifically to address the need for Certified Peer Recovery Specialists to be on call 24 hours a day, 7 days a week to respond to individuals being treated for accidental overdose. The Recovery Specialists meet with the individual survivors and their families, link them to treatment and recovery resources, provide education on overdose prevention and the use of Naloxone, provide additional resources and maintain contact after discharge to provide additional recovery supports. The program has responded to 230 overdose survivors since it began, some individuals report overdosing multiple times over the course of relapse and recovery. Of these, 83% have been referred to some form of a recovery support service. While the survivors ranged in age from 15 to 77, the highest rate of incidence was 21 to 28. 77% of the 230 had never had any formal treatment prior to their involvement hospitalization and contact with the peers involved in the AnchorED program. Survivors and hospital staff state that this program has caused a culture shift within the Emergency rooms. The concept of addiction being a disease and the lessening of the stigma previously attached to the use of drugs has been visible noticeable.

- A variety of Recovery services provided by the state’s first and largest recovery center, The Anchor. The Anchor has expanded to two new sites across RI increasing accessibility to a variety of recovery capital programs. Anchor will provide the training and supervision for the peers involved with the opioid early intervention and outreach and will serve as a primary resource to recovery addicts.
- The De-Tox program
- The Step-down program

These approaches are reflected in the action plan in Table One. In addition, BHDDH is contracting with Brown University and Johns Hopkins University to analyze community-level data to identify drug use “hotspots” and to help develop strategies to intervene in those communities to prevent overdose deaths.

- 2. Hepatitis C:** This disease, which is commonly spread through intravenous and intranasal drug use and is five times more common among “Baby-boomers” born between 1945-65, poses substantial risks to IVDUs, particularly those who are older. Because there are no symptoms of the disease, many people do not know they have it until it leads to life-threatening liver disease and other illness.

Unmet Needs: Lack of awareness among IVDUs that they are at high risk for or may already have Hepatitis C. Lack of awareness among IVDUs of risk factors, preventive measures and effective treatments for Hepatitis C.

Data: 358 (5.6%) adult SA clients within the BHDDH-licensed treatment system were reported as having a “life threatening viral illness.” Additionally 1015 (15.9%) were reported as having Hepatitis C.

Plan: In collaboration with the Department of Health, BHDDH will develop a public awareness information packet to be distributed through its treatment providers, beginning with a booth at the 2015 Rally 4 Recovery. The packet will contain information on Hepatitis C risk factors, prevention measures, test and treatment sites, and will include the CD Hepatitis C questionnaire. The Rally4Recovery event which draws thousands of Rhode Islanders also have the Department of Health truck that will be available to provide free Hepatitis C testing and Hepatitis C information.

b. Adolescents who have substance or mental health problems

Unmet Needs: Adolescence and early adulthood are when most serious mental illness and substance abuse starts. Research has shown that adolescents are particularly susceptible to developing mental illness due to rapid development, brain growth, and newly manifesting genetic risk factors. Roughly half of all lifetime mental disorders start by the mid-teens and three-fourths by the mid-20s. Young adults who are transitioning from adolescence to adulthood also face significant substance abuse-related challenges, which in Rhode Island are deepening in many respects. During this stage of life, many of the supports (emotional, institutional, financial, etc.) that living in families or foster care systems and attending schools and other community activities have provided are withdrawn. Many individuals with emerging substance use disorders become more vulnerable during this stage of life. The separation from family and community resources and supports during this life stage is compounded by the disconnection between the child and adult public systems. Individual youth generally move from a more nurturing, comprehensive, remedial and determined environment to one that is less controlling, less supportive, less remedial, less easy to access, more fragmented and more confusing.

In summary, youth and young adults face a number of significant barriers to getting the treatment and recovery supports they need:

- The experience of alienation that can come with the disconnection from family and the institutions that support children and, at the same time, the difficulty of understanding, trusting and accessing adult supports
- The lack of services that are appropriate for this stage of life
- The lack of age-appropriate recovery/resiliency aftercare supports

Data: Claim data from the MMIS for State Fiscal year 2014 identified 10,484 unique recipients ages 16-25 who incurred a claim having a primary diagnoses in the range of Mental Disorders. 3,521 unique recipients, ages 16-25, incurred a claim having a "Serious" Mental Disorder as a primary diagnosis. The most prevalent primary diagnosis in this range was for Episodic Mood Disorder at 91.4% of the recipients, followed by Other Non-Organic Psychoses at 12.8. Of the 3,217 recipients who incurred a claim having an Episodic Mood Disorder, 36.8% were Major Depressive Disorder, recurrent.

According to the 2012/2013 NSDUH, 11.32% of RI's 12-17 year olds and 9.74% of 18-25 year olds reported at least one major depressive episode in the past year. Among 18-25 year olds in RI, 4.47% report a serious mental illness in the past year; 19.93% report any mental illness and 7.34% had serious thoughts of suicide.

About one in five teenaged youth suffers from diagnosable mental health disorders, yet only approximately 20% of teens aged 12-17 received treatment.

Rhode Island's adolescents and young adults continue to experience the need for treatment for substance use disorder but don't necessarily receive services. Ten years of data from the NSDUH concerning the percentage of the population, by age range, who meet the diagnostic criteria for abuse or dependence of alcohol or drugs show that RI is consistently above the national averages across the 12-17 and 18-25 age groups, in particular. The 18-25 age range is consistently higher than the 12-17 for each year of data reported and in many cases the percentages are double, triple or quadruple that of the 12-17 age range.

This data from the National Survey on Drug Use and Health also shows the percent of the population, by age range, who need but don't receive services for substance use disorders, and Rhode Island exceeds national averages across the relevant age groups for both alcohol and drugs. As noted above with respect to tables 1 & 2, the percentage of the 18-25 age group needing but not receiving treatment for alcohol use is double, triple and in some select time frames almost quadruples that of 12-17 year olds. The ratios of RI to US are consistently higher among the 18-25 age group as well.

Plan: Rhode Island's plan to address these issues involves both system development and direct service provision. The "Now is the Time/Healthy Transition" grant-funded initiative will be the primary mover of this process. At a systems level, it will involve collaboration between BHDDH, DCYF and EOHHS and two of the state's CBHOs to develop services specific to the needs of youth/young adults ages 16-25. Services will include community awareness to reduce stigma and other barriers to help-seeking, outreach and engagement, assessment, referral and services specifically for those experiencing first episode of SMI. At the systems level, the goal will be to establish a "locus of responsibility" for services to this age group. This will involve local community oversight, a statewide oversight body that will be a committee of the Governor's Council on behavioral Health, development of collaborative funding and the institutionalization of policies that will support these innovations past the life of the grant. BHDDH has also been awarded a State Youth Treatment Planning grant, which will support the development of state-level policies to institutionalize substance abuse services to youth/young adults. A key objective of these initiatives will be to nurture an effective peer capacity, both to aid in outreach, engagement treatment and recovery and to give young consumers a leading voice in the development of the service system. BHDDH will use the 5% prevention set aside to train and employ two peer specialists to work with those experiencing first episode SMI. The Healthy Transitions Youth Director will play the lead role in the development of other peer capabilities. BHDDH's Peer Recovery training and certification initiative will assist in this effort.

Efforts will also be made to develop alternatives to adolescent residential treatment for SUDs.

Finally, BHDDH will work with the Anchor Recovery Center to develop resources that are age-appropriate to youth/young adults, and will support the development of young peers to help with that effort.

BHDDH's action steps for this population in SFY 2016 include: implementing the Healthy Transition and State Youth Planning grants; developing a state youth peer training curriculum, organizing and training a group of youth peers and adding these youth peers to the CSC treatment teams in the two Healthy Transition local areas; and engaging youth in recovery in volunteering for the Rally4Recovery event in September, 2015.

c. Children and youth who are at risk for mental, emotional and behavioral disorders, including, but not limited to, addiction, conduct disorder and depression and their families

As noted above, children in Rhode Island are at greater risk for mental health and substance use disorders due to the many risk factors associated with the fact that one in five children in RI live in poverty. The Adverse Childhood Experiences (ACE) Study examined the relationship between child maltreatment and later-life well-being and determined that childhood trauma is the single greatest preventable cause of mental illness. Children who are exposed to physical abuse, recurrent emotional abuse, sexual abuse, neglect, alcohol or drug abuser in family, an incarcerated house hold member, someone in home who is chronically depressed, or mentally ill, domestic abuse or loss of parent experience trauma. These are all factors that contribute to unsafe home environments and which place children at great risk of developing mental illness due to the trauma experienced. If the trauma associated with all these conditions are addressed when the child is young, the child has a better change of not developing mental illness and other trauma related illnesses.

More focus needs to be given to developing a trauma informed system of care which includes incorporating evidence based trauma focused treatments. One example of DCYF working with the community in developing an early intervention for addressing trauma early in a child's life is the Rhode Island Child Welfare-Early Care Partnership (2012) which developed "an infrastructure across early care systems to ensure that infants and young children in the child welfare system receive quality early care and education services that ameliorate the effects of exposure to trauma and improve their social emotional well-being to better address barriers to permanency."

High number of children and youth in out of home placement: Over the past 10 years, DCYF has made significant progress on reducing the high number of children and youth in out of home placement. Even with these reductions, RI DCYF, in 2012, had almost twice the percentage (28%) of children in care as the national average (15%) as reported by The Annie E. Casey Foundation in May 20, 2014. DCYF also has a larger percentage of children age 13 and above (46%) as compared to the national average (34%). DCYF does have combined responsibility for addressing child welfare, juvenile justice and children's mental health. The most prevalent

reason children/youth age 13 and above are placed in an out of home setting is child/youth behavior.

The following table shows the reduction in residential placement over the past 5 years and the increase in FY 2014 of the number of residential placements both in state and out of state. In FY 2014 there was also an increase in the number of maltreatment reports and completed investigation by over 600 each for the year. There has also been an increase in admissions, readmissions and length of stay in psychiatric facilities due to lack of available and appropriate step down programs in the community.

Period	Daily Residential Placement average daily	Out of State Placement average daily	Average daily residential including medical and psychiatric hospital	Average daily foster care census	Daily Psychiatric Hospitalization census (as of June 30 th of each year)
FY 2011	686	50	809	1183	
FY 2012	549	46	652	1101	24
FY 2013	507	42	615	1078	32
FY 2014	520	71	616	1144	55
FY 2015	525	82	635	1234	39

The average daily residential placement numbers are based on a point in time averaged over 12 months and includes medical and psychiatric hospital stays.

Unmet Service Needs: Despite the development of new resources and the efforts of implementing a major system change and a paradigm shift amongst the various stakeholders within the SOC, the goal of reducing the number of children and youth in congregate care has not been realized.

How DCYF will meet these needs: DCYF is in the process of reviewing the progress and challenges of redefining and restructuring its service delivery system to meet the needs of children, youth and families within a quality cost effective system of care. DCYF has developed a five year Title IV-B Child and Family Service Plan for the department. Two of the objectives from this plan include strategies and activities that specifically address this need: reduce the need for congregate care with greater emphasis on prevention-focused services and supports and increase the resource capacity of family homes to decrease the number of placement disruptions and use of congregate care.

DCYF has done extensive work on the system of care and development of community based services and the introduction of a trauma informed system. At the same time, DCYF has been focusing on strategies that improve the services within the congregate care settings to ensure that youth are receiving the appropriate level of care and for the appropriate length of time within the setting, reducing the utilization of psychotropic medications; and, ensuring that effective

aftercare supports and services are available to transition the child back home. DCYF is focused in two distinct areas:

- Slowing the entry of children into our system, and;
- Moving those in our system into a reunification or permanency situation more efficiently.

The CANS (Child and Adolescent Needs and Strengths), a nationally validated, evidence-based, standardized assessment tool with a trauma module supports effective service planning and decision-making. This has been implemented for all children and youth in congregate care settings. Other activities and initiatives include focusing on training and implementation of trauma-informed and trauma services in all aspects of work with children, youth and families and increasing the number of evidence-based programs and services available for children and youth who are in the community and are in congregate care and transitioning back home.

2. Need for Peer Support Services as part of service array: DCYF has supported a fully independent family organization that received funding through state appropriations to assist in infrastructure development, as well as providing direct support to family and youth. Family organizations provide peer support and mentoring to help families improve skills, knowledge and self-efficacy so they will be able to navigate the child/family service system more effectively. Family organizations can provide services to families whose child is at risk of developing SED as well as families who have a child already diagnosed as SED.

Unmet Service Needs: Family peer support is available through the FCCP and some community agencies but is limited in part because there is no permanent funding source in RI for peer support services. There has been much work on a state wide bases to have peer support services be billable through Medicaid and a training program has been instituted. Having peer supports has been shown to be helpful to parents and other family members including youth who have peer support when families are in crisis and struggling with issues such as poverty, homelessness, mental health, and substance abuse of parents or children. Parents could benefit from peer support, education and assistance in negotiating a system of care for which they are not familiar. This type of service provision (peer support) is very helpful to parents so that they can learn and be supported in the decision making process to address the presenting challenges instead of being opened to DCYF.

How DCYF will meet these needs: DCYF will continue to provide support for family peer support services. Through analyzing data collected in the Rhode Island Family Information System (RIFIS), DCYF has been able to show evidence that families receiving services from the FCCPs have improved functioning when they have the support and assistance of a Family Support Partners. RIFIS data is able to show the effectiveness of having peer support for families through their participation in the wraparound family team meetings. RIFIS provides a means of collecting additional information for looking at outcomes and providing services to those families involved with the FCCPs who have children at risk of developing SED.

3. Development of community based and evidence based services: The DCYF system of care transformation has required the development of a robust continuum of services that can effectively meet the needs of children, youth and families in a community setting. At the core of DCYF's efforts to realize such a system is the development and implementation of evidence based and promising practices for addressing the needs of children and their families. DCYF has been working closely with the Executive Office of Health and Human Services, Neighborhood Health Plan/Beacon, and community providers to make these services available. Current EBPs that are available include, but are not limited to, Multi-Systemic Therapy, Parenting with Love and Limits, Alternatives for Families – Cognitive Behavioral Therapy, Triple P, and Strengthening Families, with others in various stages of implementation. This array of EBPs provides the following:

- Places a greater focus on prevention and early intervention programs, instead of waiting to intervene until after problems occur. The benefit: addressing root causes head on as early as possible.
- Invests in proven programs that have a track record of benefiting children and families and make them available for every eligible child. Not only are these programs proven to work, they are also matched to the neighborhood's strengths and needs.
- Creates strong partnerships among public systems and schools and the families and communities they serve.

Unmet Service Needs: Much attention has been given to identifying the best evidence based practices for a variety of issues and problem areas. Even after identifying the best evidence based practices, the initial cost in time and money of obtaining the rights to use the program, the training, supervision and cost of materials, and then the advertising and recruitment of participants and the ongoing funding mechanism need to be addressed. All these requirements to start an evidence based practices are significant. Some organizations have received seed money to start evidence based programs, but there is a sizable need for additional seed money to develop and implement those evidence based practices that have been found to be effective in meeting the specific needs of children. Moreover, some EBPs have been approved for payment through health insurance or Medicaid but this funding does not cover all the cost of the programs. And some EBP's do not meet the requirements for funding through insurance or Medicaid and must be paid by other funding sources.

There are still not enough community based programming and there is underuse of new evidence based and community programs based on not trusting that these programs can provide the services needed by the child/youth/family.

How DCYF will meet these needs: DCYF will continue to develop and utilize a continuum of care that includes an expansion of evidence based services. DCYF was awarded a title IV-E Waiver. The focus of this demonstration project is: Reducing Reliance on Congregate Care and Increasing Community-Based Service Supports for Children and Families.

In selecting new programs and services, DCYF will adhere to procurement procedures that require proposals to be submitted through a formal Request for Proposals (RFP) process. An internal review body within DCYF is comprised of representatives from Child Welfare, Juvenile

Corrections, Children's Behavioral Health, and Management and Budget. This body reviews and scores proposals and recommends the selection(s) to the Department Director for finalization.

In order to move forward and continue the previous decrease in use and reliance on residential treatment, a greater diversity and availability of intensive community based and evidence based services that are trauma informed need to be available to meet the individual needs of children and families and access to those services needs to be improved statewide.

DCYF's strategy is to develop and expand the use of community based and evidence based practices that focus on working with the family and child/youth in the community to prevent removal and promote wellness. Mobile crisis response is an example of the type of service that DCYF would like to make more widely available, as this has proven effective in preventing hospitalization and long-stays in residential programs for children at risk of SED or with SED.

Another strategy is to expand and increase the array of community-based services to support reunification, shorten the length of stay in out of home placement and prevent re-entries into care. These activities include focusing on training congregate care staff on providing trauma-focused care.

4. Limited resources for data analysis and data-based planning: DCYF has two main MIS systems, RICHIST for children and families open to DCYF, and RIFIS for children families receiving services through the FCCP and not open to DCYF. RICHIST continues to be a valuable information tool to DCYF. RICHIST has maintained the ability to track and identify the status, demographics, location and service plan goal for the placement of children in foster care. The location of a child's whereabouts is recorded in RICHIST regardless of whether the child is in a paid, unpaid, unlicensed, or voluntary placement.

Yale has provided much of DCYF's data analysis and comprehensive reports on data both in RICHIST and RIFIS. In addition, results from the CANS and other functional assessments are collected in the EOHHS Community Supports Management module of the Human Service Data Warehouse. Data is now available on children in placement and initial reports show areas of need through the use of the CANS but further development and analysis is needed.

Critical Gap: Since DCYF uses two different MIS systems (RICHIST and RIFIS) for collecting client specific data, it is difficult and time consuming to produce reports that analyze the effectiveness of wraparound services, and specifically whether the preventive, diversionary process is working to support families who are at risk for DCYF involvement and whose children who are mentally, emotionally and behaviorally challenged to prevent placement and hospitalization. Limitations of RICHIST are due to the fact that it is a 17 year old system and while it currently supports the functional requirements of the department (tracking placements, service plans, costs, demographics, outcomes, etc.), it is limited in its ability to support a mobile, field-based workforce. Community providers use a variety of other MIS systems.

How DCYF will meet this gap: DCYF has reviewed and coordinated presentations by external vendors (some of which was in collaboration with Annie E. Casey) on potential options to upgrade RICHIST and allow for web-based access and data entry by service providers. DCYF is

working with the Executive Office of Health and Human Services (EOHHS) data warehouse to explore options for the EOHHS Data warehouse to produce dashboards with enhanced functionality such as data layering and turning on and off certain analysis parameters. Another option DCYF is exploring is upgrading SAS (statistical analysis software) graphing capabilities that would allow DCYF to produce graphs directly aligned with the DCYF's statistical analysis reports. DCYF anticipates this review process will continue with the aim of finalizing the decision in the fall of 2015.

d. Women who are pregnant and have a substance use and/or mental disorder.

e. Parents with substance use and/or mental disorders who have dependent children.

Unmet Needs: Public funding for residential treatment for substance abusing moms and their infants has become increasingly strained since the initiation of managed care. The managed care agencies are arraigning care managers to help coordinate care but with the changes with Medicaid expansion in RI this transition is of concern. In addition this of course increases the chances for the moms to relapse. Using the full continuum of ASAM levels of care and the new managed care system has led to a shorter amount of time in residential treatment which appears to be an inadequate amount of time for DCYF to successfully reunite some families.

The incidence of RI infants born with Neonatal Abstinence Syndrome, (NAS) has risen to more than 95 babies in this past year at Women and Infants Hospital alone. At present RI has no detox services for opioid dependent pregnant women who are unwilling to use methadone or buprenorphine. Although the use of medication assisted treatment helps stabilize the mothers, helps reduce criminal activity and promotes better connections to prenatal care, when they do reach out they are often met with judgmental and punitive responses from social service agencies who are unfamiliar with treatment benefits. Many of these mothers do not disclose their drug use during pregnancy due to stigma around NAS and substance use disorders in general. The use of Peer Recovery Specialists for pregnant moms with substance abuse disorders is essential for this often marginalized population, and can assist both moms and infants with resources to promote the best chances for a safe recovery.

Plan: The Department is collaborating with the Division of Medicaid to ensure that the Managed Care contracts include language regarding prioritization for treatment to women for are pregnant or have dependent children. The Managed Care contracts currently incentivize healthy births and the Department will education the managed care plans on the Block Grant requirements to ensure that our combined goals are met. The BHDDH behavioral health provider licensing regulations ensure access to treatment and this language will be written into all contracts. The Department will also continue to require all licensed providers to post notice of the treatment access requirements for women's services in prominent areas. The Department will increase its education and awareness campaign to include outreach to prevention coalitions, parent/teachers organizations and community based agencies.

3. Services for persons with or at risk of contracting communicable diseases:

Tuberculosis – Rhode Island continues to have a low incidence of tuberculosis infection. According to Department of Health data, there were a total of 21 cases of the disease in 2014. The majority were among Hispanic people, and 16 of the 21 were among foreign born individuals.

What the state will do: The state will continue to require, through licensing regulations, all Medication Assisted Treatment, residential, and medical detoxification treatment programs to provide or arrange for a physical, which included necessary laboratory work to include tuberculosis (PPD-Mantoux) testing. In addition, the contracts with treatment programs specify that the program must routinely make available tuberculosis services directly or through arrangements with other entities to all individuals receiving treatment for substance abuse. Staff will continue to review client records to test compliance with licensing regulations as part of the routine site visit.

4. Services for individuals in need of primary substance abuse prevention

State Epidemiological Outcomes Workgroup (SEOW): The Rhode Island State Epidemiological Outcomes Workgroup's (SEOW) main goal is to institutionalize data-driven decision making for state and community level prevention planning and to expand the focus to integrate behavioral health indicators such as preventing mental illness and promoting positive mental health as it relates to substance use and mental health. Overall, data points on consumption patterns (i.e., current smoking and drinking, or age of first use) and mental health (i.e., depression symptoms or suicide attempts) from various sources will be integrated into a single data-file under the proposed data collection activities. The newly identified indicators relevant to mental health are: depression and other mental health problems, life satisfaction, depression symptoms in the last 30 days, post-partum depression symptoms, depression in the past 12 months, Medicaid utilization of mental health services, number of children receiving mental health services for emotional disorders, and psychiatric hospitalization admissions, suicide ideation/plans/attempts/deaths, were added to the already existing substance use data collected under the previous SEOW project. Every effort will be made to identify and access additional sources of potential behavioral health indicators (such as episodes of depression, psychological distress, suicide ideation/attempt, etc.) and intervening variables (such as domestic violence, child abuse, etc.).

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

time were higher in RI as compared to the United States; and rates of RI population needing but not receiving treatment for drug and alcohol use exceed the national averages.

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

2015 SEOW KEY FINDINGS

LONG- and SHORT- TERM CONSEQUENCES OF SUBSTANCE USE

- Several long-term adverse consequences remain elevated in Rhode Island, as compared to the United States averages. This is especially the case for malignant neoplasm deaths, heart disease deaths, and chronic liver disease and cirrhosis deaths, whose rates in **2012** are greater in Rhode Island than in the entire U.S.
- Since 2007, rates of chronic lower respiratory diseases deaths increased in Rhode Island as compared to the rest of the nation.
- RI had increased rates of fatal motor vehicle crashes involving alcohol in 2010 and **2012** (29% and 30% greater than the U.S.). In 2007 the RI fatal motor vehicle crashes were equal to the national average.
- Rates of drivers in fatal motor vehicle crashes involving alcohol remain higher as compared to the United States averages.

KEY MENTAL/BEHAVIORAL INDICATORS

Table 1 shows mental health indicators for RI as compared to the United States. The prevalence of lifetime depression among adults in RI compared to the U.S. was at a higher proportion from 2011 to 2013. Suicide deaths among adults and feelings of sadness/hopelessness among youth were similar in RI and the United States. RI had 18% lower rate of youth suicide ideation and 27% lower rate of youth suicide plans, as compared to the United States. However, rates of youth suicide attempts were greater in RI, as compared to the United States shown in Table 2.

TABLE 1

RI vs. US Comparison on General Mental Health Indicators

Indicator	Year	RI	US	Ratio RI/US
General Population				

Lifetime Depression (BRFSS)	2011	22.0%	17.5%	1.26
	2012	20.3%	17.6%	1.15
	2013	22.2%	18.7%	1.19
Post-partum depressive symptoms (PRAMS)	2009	11.9%	11.9%	1.00
	2010	11.3%	11.7%	0.97
	2011	10.3%	10.1%	1.02
Suicide Deaths (NVSS)	2010	0.123	0.124	0.99
	2011	0.096	0.127	0.76
	2012	0.100	0.129	0.78
Youth Population				
Felt sad/hopeless almost every day for 2+ weeks in a row in past year (YRBS)	2009	25.0%	26.1%	0.96
	2011	24.6%	28.5%	0.86
	2013	25.8%	29.9%	0.86
Youth suicidal ideation (YRBS)	2009	11.8%	13.8%	0.86
	2011	12.3%	15.8%	0.78
	2013	13.9%	17.0%	0.82
Youth suicidal plans (YRBS)	2009	11.3%	10.9%	1.04
	2011	10.7%	12.8%	0.84
	2013	9.9%	13.6%	0.73
Youth suicide attempts (YRBS)	2009	7.7%	6.3%	1.22
	2011	8.7%	7.8%	1.12
	2013	14.3%	8.0%	1.79

Sources: Behavioral Risk Factor Surveillance System (BRFSS), Pregnancy Risk Assessment Monitoring System (PRAMS), National Vital Statistics System (NVSS), Youth Risk Behavior System (YRBS)

TABLE 2

RI vs. Regional Comparison on Youth Suicide Attempts

	USA	RI	CT	MA	ME	NH	NJ	NY	PA	VT
	Youth suicide attempts									
2009	6.3%	7.7%	7.4%	6.8%	7.9%	4.7%	--	7.4%	5.7%	4.3%
2011	7.8%	8.7%	6.7%	6.8%	7.6%	6.1%	6.0%	7.1%	--	3.6%
2013	8.0%	14.3%	8.1%	5.5%	8.1%	6.7%	9.9%	7.1%	--	5.6%

Source: YRBS

ALCOHOL and DRUG ABUSE/DEPENDENCE DSM-IV DIAGNOSES

- Rates of **alcohol**-related DSM-IV diagnoses in Rhode Island varied, the rate increased from 2007 to 2010 and decreased from 2010 to **2012**, although rates were higher as compared to the United States.
- Rates of **drug**-related DSM-IV diagnoses in Rhode Island also varied, the rate decreased from 2007 to 2010 and increased from 2010 to **2012**, although rates were higher as compared to the United States. However, rates of drug- related diagnoses decreased from 2007 to **2012**.
- Rates of alcohol-related diagnoses exceed national average by 27% by 2012 and for drug-related diagnoses by 37% by 2012.

TABLE 3

RI vs. US Comparison on 12 indicators of adverse consequences of substance use (2007-2012)

Substance Use Consequence	2007			2010			2012		
	RI	US	Ratio RI/U S	RI	US	Ratio RI/U S	RI	US	Ratio RI/U S
Malignant Neoplasms Deaths	2.09	1.87	1.12	2.15	1.86	1.16	2.05	1.86	1.10
Heart Disease Deaths	2.60	2.04	1.27	2.21	1.94	1.14	2.25	1.91	1.18

Chronic Lower Respiratory Disease	0.40	0.42	0.94	0.48	0.45	1.08	0.48	0.46	1.05
Chronic Liver Disease and Cirrhosis	0.11	0.10	1.15	0.12	0.10	1.14	0.13	0.11	1.19
Suicide	0.09	0.12	0.79	0.12	0.12	0.99	0.10	0.129	0.78
Assault (Homicide)	0.02	0.06	0.38	0.03	0.05	0.49	0.03	0.05	0.55
Fatal MV Crashes inv. Alcohol	31%	31%	1.00	40%	31%	1.29	39%	30%	1.30
Drivers in Fatal MV Crashes inv. Alcohol	33%	26%	1.27	36%	26%	1.38	34%	25%	1.36
Violent Crime	2.27	4.72	0.48	2.57	4.05	0.63	2.52	3.87	0.65
Property Crime	26.23	32.76	0.80	25.57	29.46	0.87	25.72	28.59	0.90
DSM-IV Alcohol Abuse/Dependence	7.8%	7.5%	1.04	9.1%	6.8%	1.34	8.5%	6.7%	1.27
DSM-IV Drug Abuse/Dependence	4.4%	2.8%	1.57	2.9%	2.7%	1.07	3.7%	2.7%	1.37

Note: Ratios greater than 1 indicate those consequences where RI exceeds the national average.

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

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

Sources: National Vital Statistics System (NVSS), Fatality Analysis Reporting System (FARS), Uniform Crime Reports (UCR), National Survey of Drug Use and Health (NSDUH)

ADOLESCENT PREVALANCE DATA

MARIJUANA and ILLICIT DRUG USE

Data from the 2009 and 2011 State Epidemiologic Profile indicate that 26 percent of Rhode Island students reported use of marijuana in the previous 30 days. Since then, in 2013 the proportion of RI students decreased to 24% who reported use of marijuana in the past month. This prevalence rate was higher than the national average, as determined by Youth Risk Behavior Surveillance System (YRBS). In addition, in 2013, RI students had decreased initial use of marijuana before age 13 as compared to the United States. Since 2001, trends decreased from 33% to 24% among RI students who reported using marijuana in the past month. In both

	RI	US		RI	US		RI	US		RI	US	
Alcohol Use												
Alcohol use past month	50.3	47.0	1.07	34.0	41.8	0.81	30.0	38.7	0.78	30.9	34.9	0.89
Binge drinking past month	30.7	29.9	1.03	18.7	24.2	0.77	18.3	21.9	0.84	15.3	20.8	0.74
Initial use of alcohol before age 13	29.7	29.1	1.02	15.8	21.1	0.75	15.6	20.5	0.76	13.5	18.6	0.73
Drinking and driving past month	15.5	13.3	1.17	7.2	9.7	0.74	6.5	8.2	0.79	8.5	10.0	0.85
In car w/ driver who had been drinking	32.3	30.7	1.05	23.1	28.3	0.82	21.9	24.1	0.91	20.1	21.9	0.92

2011 and 2013, Rhode Island high school students reported lower misuse of prescription drugs than the national average.

TABLE 4

RI vs. US Comparison on 10 Key Consumption Indicators for Underage Population (<18),

Cigarette Use												
Smoking cigarettes 20+ days past month	14.2	13.8	1.03	5.4	7.3	0.74	4.4	6.4	0.69	3.1	5.6	0.55
Initial use of tobacco before age 13	22.3	22.1	1.01	8.4	10.7	0.79	7.1	10.3	0.69	5.6	9.3	0.60
Marijuana Use												
Using marijuana past month	33.2	23.9	1.39	26.3	20.8	1.26	26.3	21.3	1.23	23.9	23.4	1.02
Initial use of marijuana before age 13	12.8	10.2	1.25	8.3	7.5	1.11	7.1	8.1	0.88	6.8	8.6	0.79
Prescription Drug Use												
Prescription drug misuse past year	--	--	--	--	--	--	14.1	20.7	0.68	13.5	17.8	0.76

Note: Ratios greater than 1 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 1 indicate those consumption patterns where RI is lower than the US average

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

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

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

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

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

BHDDH - Each treatment provider licensed by the Division of Behavioral Healthcare is required to submit client-level data on all clients receiving services, regardless of pay source. Data submissions contain a single record of admission and discharge information for each program episode of every client treated during the reporting period.

For methadone service providers: Client data is to be entered on-line or uploaded in a properly formatted file at least daily for methadone clients to facilitate clearing of clients and ensure that clients are only active in one program at a time. Each daily submission is to contain records on all client admissions, discharges, and any updates to client records for the previous day.

For all remaining service providers: Client data is to be entered on-line or uploaded in a properly formatted file at least monthly. Each monthly submission is to contain records on all client admissions, discharges, and any updates for clients continually served during the reporting period (i.e., with an "open/active" record).

DCYF has two main systems for collecting data, both of which are capable of collecting and reporting data at the client, program, and provider level. The Rhode Island Children's Information System (RICHIST) for children and families involved with DCYF and the Rhode Island Family Information System (RIFIS) for those families receiving services through the Family Care Community Partnership. DCYF developed a single information management system, (RICHIST) that includes case management, staff management, financial management, provider management and policy and procedure management functionality. RICHIST also supports demographic, behavioral, medical and legal data collection and a range of continuous quality improvement tasks. RICHIST data system for managing cases open to Family Court has been updated to support the needs of the Family Care Networks and care coordination services. Additional information technology solutions could be programmed that would support information sharing and coordination, as well as and the collection and analysis of expanded outcomes data. This is an ongoing process.

The Rhode Island Family Information System (RIFIS), a web based data information system was designed to support the collaborative work of families and providers in the FCCPs. RIFIS captures data and outcomes to assist each stakeholder in the system with better management tools to assess effectiveness. It is able to produce reports at the client, program, individual and partnership provider level, and by each FCCP or entire program. Quarterly, semi-annual reports and annual reports that reflect outcomes and adherence to practice standards are able to be produced and evaluated. In addition, data is also collected in the EOHHS Community Supports Management module of the Human Service Data Warehouse on results of the CANS. RICHIST data is uploaded on a weekly basis to the EOHHS Human Service Data Warehouse.

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

BHDDH - The same data is collected into the same system for all substance abuse and mental health service recipients. This is a stand-alone database and is not used to collect any other data. However, this data can be crossed with claims data, and OEI data for further analysis.

DCYF—Currently, DCYF's systems are specific to population and function, although work is being done to coordinate with a larger system. For example, DCYF has been receiving and analyzing psychotropic medication data from the state's out-of-home Medicaid managed health care plan, Neighborhood Health Plan.

- 3. Is the state currently able to collect and report on the draft measures at the individual client level (that is, by client served, but not with client-identifying information)?*

BHDDH - We currently do not collect the "Perception of Care" measures for adults. To do so we would need to add them to something else that we collect, perhaps the OEI.

We could collect NQF-0104 for adults based on their diagnoses. We would not be able to report on recurrent episodes of major depressive disorder.

We could collect the NSDUH - SUI02, however, there is often a delay in reporting from year to year. My comment would be that if SAMHSA can get it directly, why would we need to report it?

NQF-0710: we do not require our providers to collect PHQ-9 scores or track them over time. This would be an unfunded mandate for them.

NQF—0028: we collect data on whether or not people smoke, we could cross that with claims data to see if they received any services for smoking cessation. However our system overwrites previous data so it would be difficult to know if the treatment was effective if providers do not update the clients file or know if they were trying to quit using tobacco.

"Percentage of individuals 12 or older who used any tobacco product in the past 30 days." We collect data on people's tobacco use at intake, but do not ask if they have smoked in the past 30 days. This would require changing our system.

NQF-2152, Prescription Drug Misuse and Marijuana misuse: we collect data on client's primary, secondary and tertiary substance use issues including alcohol, prescription drugs and marijuana. Typically clients are put into the system because they have these issues and are seeking treatment. We do not collect data on their recovery from substance misuse. This would require a system change.

We already collect data on client's employment status, criminal justice involvement, and housing status at intake.

We collect data on client's educational level and if they are attending school at intake.

DCYF - At this time, DCYF does not collect and report on the draft measures related to children for perception of Care-CAHPS_Hedis Medicaid Child four questions on patient-centered/family involvement in care.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

BHDDH - As noted above, the state would have to make systemic changes in the BHOLD system and potentially the OEI. The state would need some technical assistance to find a way to collect the recovery components being suggested.

DCYF would need to incorporate this requirement into any contract for service or internal system in order to provide this information. Technical assistance may be necessary to set up system to collect and provide this information for the MH BG.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
 Priority Area: Adolescents
 Priority Type: SAP
 Population(s): Other

Goal of the priority area:

Reduce alcohol, marijuana and prescription drug use, misuse and abuse.

Objective:

A measurable reduction in the percent of in-school, high school-aged (grades 9-12) youth reporting current (past 30-day) use of marijuana, alcohol and other drugs; and a measurable increase in the percent of in-school, high school-aged youth expressing disapproval of the use of marijuana and other drugs.

Strategies to attain the objective:

Evidence-based programming directed at the entire school population, including students and staff- Universal Indirect; evidence based programming for an entire grade of students- Universal Direct; and evidence-based programming for students at high or highest risk for substance use- Selected and/or Indicated.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Percentage of youth reporting current and 30 days use of alcohol, marijuana and prescription drugs. Percentage of youth expressing disapproval of the use of alcohol, marijuana and other drugs.
Baseline Measurement:	2013 data shows that school aged (grades 9-12) alcohol use rates in the past month at 30.9%; school aged marijuana use in the past month 23.9% and school aged prescription drug use in the past month 13.5%.
First-year target/outcome measurement:	To maintain the 30 day use of underage drinking of alcohol below the national average of 34.9% and lower it by 1%. To decrease 30 day use of marijuana by 1%.. To maintain 30 day prescription drug misuse below the national average of 17.8% and lower it by 1%. To increase school aged perception of risk of using alcohol, marijuana and prescription drugs.
Second-year target/outcome measurement:	To maintain the 30 day use of underage drinking of alcohol below the national average of 34.9% and lower it by 1%. To decrease 30 day use of marijuana by 1%.. To maintain 30 day prescription drug misuse below the national average of 17.8% and lower it by 1%. To increase school aged perception of risk of using alcohol, marijuana and prescription drugs.

Data Source:

Rhode Island Student and Youth Risk Behavior Surveys, and evaluation.

Description of Data:

The Rhode Island Student Survey is a risk and prevalence survey that is administered bi-annually in 11 schools. This will be expanded to include 12 schools under the Partnerships for Success Grant and 46 schools under Student Assistance Services. The Youth Risk Behavior Survey is administered bi-annually to a school sample.

Data issues/caveats that affect outcome measures::

We will not administer the Rhode Island Student Survey until spring 2016.

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

Priority Type: MHS

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

Goal of the priority area:

Maintain children at risk of BH disorders in their home and community or in the least restrictive setting as possible through building and supporting community based programs that provide prevention, support, education and services to children, youth and families.

Objective:

Children, youth and families are able to participate in evidence based programs that promote wellness and are trauma informed. Children, youth and families are able to express voice and choice and be a part of the decision making process and building their own support system

Strategies to attain the objective:

Increase knowledge and use of evidence based services through provision of parent education and/or peer support and availability of evidence based parenting, support services, community education, workshops to educate parents

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Parent support organization staff engages with and provides peer support services through attendance at planning meetins, helps youth and parents develop their own support network, provide education about resources and attendance at Family Team Meeting addressing service needs in FCCP programs

Baseline Measurement: 215 families served through visits, meetings, phone calls, parent programs

First-year target/outcome measurement: 230

Second-year target/outcome measurement: 240

Data Source:

Provider reports and RIFIS

Description of Data:

Data includes some demographic information or specific information about attendance or participation in educational activities

Data issues/caveats that affect outcome measures::

Priority #: 3

Priority Area: Homeless with SMI

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase access to treatment and recovery services home homeless individuals with SMI

Objective:

Increase numbers who gain eligibility to SSI/SSDI through SOAR program
Increase access to behavioral health services more intensive than screening
Provide more permanent supportive housing

Strategies to attain the objective:

Coordinate with SOAR program
Increase contract requirements with PATH program and include contract requirements for new CABHI program that mandate numbers served with behavioral health services more intensive than screening

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of successful SOAR applications
Baseline Measurement: 21/year
First-year target/outcome measurement: 24/year
Second-year target/outcome measurement: 27/year

Data Source:

Report from State SOAR Coordinator

Description of Data:

Count of successful SOAR applications in year

Data issues/caveats that affect outcome measures::

None

Indicator #: 2
Indicator: Number of PATH and CABHI consumers receiving behavioral health services more intensive than screening
Baseline Measurement: establish baseline
First-year target/outcome measurement: 10% above baseline
Second-year target/outcome measurement: 10% above year 2 number

Data Source:

PATH and CABHI program annual reports

Description of Data:

HMIS reports used by PATH and CABHI programs do not track specific behavioral health services, so Rhode Island's programs will require reports in addition to HMIS-based reports that track behavioral health services more intensive than screenings.

Data issues/caveats that affect outcome measures::

so above

Indicator #: 3
Indicator: Number of PATH and CABHI clients who begin to receive housing retention supports in permanent housing in FY
Baseline Measurement: 35 in SFY 2015
First-year target/outcome measurement: 100
Second-year target/outcome measurement: 100

Data Source:

PATH and CABHI annual provider reports

Description of Data:

Data collected as part of HMIS-based reporting system.

Data issues/caveats that affect outcome measures::

none

Priority #: 4

Priority Area: Children with SED and their families

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Objective:

1. Reducing the use of and length of stay of out of home placements through development and implementation of evidence based programs
2. Increasing access to support services and community based treatment

Strategies to attain the objective:

1. Increase use of evidence based family-focused treatment, parenting education and peer support for families with children, youth in out of home placement including hospitalization or at risk for out of home placement
2. Increase access through family education support services by attending community meetings, community education, conferences, workshops to educate parents on risk factors, trauma, and resources

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of parent with children meeting definition of SED receiving evidence based parenting education and/or peer support

Baseline Measurement: 215 yearly

First-year target/outcome measurement: 230

Second-year target/outcome measurement: 240

Data Source:

Provider reports and RIFIS

Description of Data:

Basic demographic data and information concerning SED of child and service and dates of service

Data issues/caveats that affect outcome measures::

Location of child/youth and if in out of home placement, determination of SED criteria

Priority #: 5

Priority Area: Increased identification and treatment for IVDU with Hepatitis C

Priority Type: SAT

Population(s): IVDU

Goal of the priority area:

Reduce undiagnosed and untreated hepatitis C among IVDU

Objective:

Engage IVDU in testing and treatment for hepatitis C

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 0
Indicator: Number of individuals tested for Hepatitis C at Rally4Recovery
Baseline Measurement: 0
First-year target/outcome measurement: 100
Second-year target/outcome measurement: 150

Data Source:

Number of individuals tested at Rally4Recovery as reported by R4R hepatitis booth staff

Description of Data:

Count of number of tests administered

Data issues/caveats that affect outcome measures::

none

Priority #: 6
Priority Area: Reduce opioid overdose deaths
Priority Type: SAT
Population(s): IVDUs

Goal of the priority area:

Reduce the number of accidental opioid overdose deaths

Objective:

1. Develop community strategies to reduce overdose deaths in high drug-use "hot spots"
2. Promote community response to opioid abuse, careful prescribing practices and use of Narcan
3. Support overdose survivors to seek treatment and recovery services

Strategies to attain the objective:

1. Contract with Brown University and Johns Hopkins University to conduct analysis of drug abuse data and assist BHDDH in developing a community action plan targeting drug use "hot spots"
2. Conduct community forums, grand rounds for prescribers and other public awareness
3. Train and deploy peer support specialists to engage overdose survivors in EDs and hospitals and to support survivors in seeking treatment and recovery services

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of OD survivors referred by hospital EDs and responded to by Anchor ED peer support staff
Baseline Measurement: 230
First-year target/outcome measurement: 300
Second-year target/outcome measurement: 300

Data Source:

AnchorED reports

Description of Data:

Count of referrals received and responded to kept by AnchorED and reported quarterly to BHDDH program monitor

Data issues/caveats that affect outcome measures::

Dependent on the rate of overdoses

Priority #: 7
Priority Area: Licensed behavioral health provider clients infected with tuberculosis
Priority Type: SAT
Population(s): TB

Goal of the priority area:

Maintain or reduce the number of clients of licensed behavioral health providers who are infected with TB

Objective:

Licensed behavioral healthcare providers comply with regulatory requirements for infection control, testing, counseling, testing and evaluation of clients around TB.

Strategies to attain the objective:

Monitor compliance with state regulations regarding tuberculosis using the Substance Abuse Treatment Block Grant and Mental Health Block Grant Monitoring Checklist and other monitoring strategies.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Licensed behavioral healthcare providers comply with all TB-related regulations
Baseline Measurement: to be established
First-year target/outcome measurement: 50% over baseline
Second-year target/outcome measurement: 75% over baseline

Data Source:

BHDDH Program Monitor biannual reports

Description of Data:

Bi-annual reports using SABG and MHBG Monitoring Checklist

Data issues/caveats that affect outcome measures::

Reports are done bi-annually

Indicator #: 2
Indicator: Number of licensed behavioral healthcare provider clients with untreated tuberculosis
Baseline Measurement: to be established
First-year target/outcome measurement: to be established
Second-year target/outcome measurement: 10% reduction over year one

Data Source:

RIBHOLD system reports

Description of Data:

RIBHOLD is the state's IT system for licensed behavioral healthcare providers. Reports go to BHDDH monthly

Data issues/caveats that affect outcome measures::

Current RIBHOLD system does not track TB, and DOH data applies to all state residents, without identifying behavioral healthcare clients. BHDDH will add a field for TB in its redesign of RIBHOLD, but this may not be fully operational in year one.

Priority #: 8
Priority Area: Pregnant, SA women and SA women with dependent children
Priority Type: SAT
Population(s): PWWDC

Goal of the priority area:

Ensure that all PWWDC have timely access to substance abuse treatment as described in SABG standards

Objective:

1. Ensure that all licensed behavioral healthcare provider contracts contain requirements for timely access to care as described in SABG
2. Increase public awareness among consumers and service provider agencies as to access-to-care standards
3. Understand any gaps/unmet needs for interim therapeutic services, especially with regard to dependent children

Strategies to attain the objective:

1. Review all licensed bh provider contracts and amend all contracts as necessary to include PWWDC treatment access requirements
2. Conduct outreach to community organizations, providers and insurers about treatment access requirements
3. Conduct Survey Monkey with bh providers to determine needs/gaps in therapeutic services for PW, WWDP and dependent children

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of licensed behavioral healthcare providers that display BHDDH women's service posters
Baseline Measurement: 100%
First-year target/outcome measurement: 100%
Second-year target/outcome measurement: 100%

Data Source:

Bi-annual reports by Program Monitors

Description of Data:

Reports using SABG and MHBG Monitoring Checklist

Data issues/caveats that affect outcome measures::

Reports are done bi-annually

Indicator #: 2
Indicator: Number of licensed bh providers whose contracts reflect state regulation requirements for women's treatment services
Baseline Measurement: none
First-year target/outcome measurement: 50%
Second-year target/outcome measurement: 100%

Data Source:

Report of BHDDH Contract Monitors

Description of Data:

Report by Contract Monitors that each new contract's requirements match those of state regulations regarding women's treatment services

Data issues/caveats that affect outcome measures::

Contracts may require RFP/purchasing process to modify

Priority #: 9
Priority Area: Transition age youth and young adults, ages 16-25, with SED and SMI
Priority Type: MHS
Population(s): Other (Adolescents w/SA and/or MH)

Goal of the priority area:

Increase utilization of behavioral health services by youth/young adults ages 16-25

Objective:

- 1. Increase participation in age-appropriate behavioral health early-intervention, treatment and recovery services
2. Increase capacity for peer-delivered services to youth/young adults
3. Increase youth/young adult volunteer participation in Rally4Recovery

Strategies to attain the objective:

- 1. Implement Healthy Transitions grant
2. Develop peer curriculum and certification for youth/young adult services and employ certified peers in Healthy Transitions program
3. Recruit youth/young adult volunteers for Rally4Recovery

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of youth/young adults receiving outreach, assessment and treatment services through Healthy Transitions grant program
Baseline Measurement: HT treatment program starts in 10/15 - no baseline
First-year target/outcome measurement: 400
Second-year target/outcome measurement: 500

Data Source:

Healthy Transitions information system

Description of Data:

University of Rhode Island designed information system for Healthy Transitions research component

Data issues/caveats that affect outcome measures::

Only eight months of service data for year one. Baseline could not be established because in 2015 there was no comparable package of services and no way to determine how many individuals were receiving equivalent services. The first and second year targets are service outcomes required by contract with the providers.

Indicator #: 2
Indicator: Number of youth/young adults who volunteer for Rally4Recovery in 2015 and 2016
Baseline Measurement: none-new project
First-year target/outcome measurement: baseline TBD

Second-year target/outcome measurement: 10% over year one

Data Source:

Rally4Recovery website

Description of Data:

Number of youth/young adults who register on Rally4Recovery website

Data issues/caveats that affect outcome measures::

More youth/young adults may volunteer on day of event than have registered on website

Priority #: 10

Priority Area: Hospital use by adults with SMI

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Reduce unnecessary unnecessary psychiatric hospital use

Objective:

Reduce unnecessary ED services, hospital admissions and re admissions, and lengths of stay at psychiatric hospitals

Strategies to attain the objective:

Modify CMHO contracts to create incentives to reduce 30 day re-admissions to hospital and emergency department use by Health Home clients
Use peer support staff of Health Homes to help SPMI and SMI clients engage with community supports

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Rate of Health Home clients per thousand using emergency departments

Baseline Measurement: 28%

First-year target/outcome measurement: 26%

Second-year target/outcome measurement: 25%

Data Source:

MMIS

Description of Data:

Medicaid claims data for Health Homes

Data issues/caveats that affect outcome measures::

none

Indicator #: 2

Indicator: Number of Health Home clients readmitted to psychiatric hospital beds within 30 days

Baseline Measurement: 7

First-year target/outcome measurement: 6

Second-year target/outcome measurement: 6

Data Source:

MMIS

Description of Data:

Medicaid claims data for Health Homes

Data issues/caveats that affect outcome measures::

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$7,572,042		\$0	\$1,573,000	\$370,296	\$0	\$0
a. Pregnant Women and Women with Dependent Children*	\$649,336		\$0	\$0	\$0	\$0	\$0
b. All Other	\$6,922,706		\$0	\$1,573,000	\$370,296	\$0	\$0
2. Substance Abuse Primary Prevention	\$6,772,186		\$0	\$70,000	\$156,606	\$180,000	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
4. HIV Early Intervention Services	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$754,960		\$0	\$1,644,032	\$1,799,694	\$0	\$0
11. Total	\$15,099,188	\$0	\$0	\$3,287,032	\$2,326,596	\$180,000	\$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planned expenditures based on a single block grant cycle and two years of state, federal and local planned expenditures.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$0	\$0	\$0	\$0	\$0
6. Other 24 Hour Care		\$0	\$0	\$0	\$0	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$3,037,694	\$0	\$3,058,172	\$0	\$0	\$0
8. Mental Health Primary Prevention**		\$0	\$0	\$0	\$0	\$0	\$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		\$168,760	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$168,760	\$0	\$727,426	\$2,257,992	\$0	\$0
11. Total	\$0	\$3,375,214	\$0	\$3,785,598	\$2,257,992	\$0	\$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planned expenditures based on a single block grant cycle and two years of state, federal and local planned expenditures.

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	\$	\$
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	\$	\$160,000

Screening, Brief Intervention and Referral to Treatment ;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	\$3,386,093	\$
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	\$330,000	\$
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	\$	\$
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		

Consultation to Caregivers;		
Medication Services	\$550,000	\$
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	\$557,275	\$257,288
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

Recovery Supports	\$	\$1,119,636
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	\$	\$
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		

Interactive Communication Technology Devices;		
Intensive Support Services	\$	\$321,246
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	\$2,127,236	\$
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		

Therapeutic Foster Care;		
Acute Intensive Services	\$	\$
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	\$221,690	\$1,354,284
Total	\$7,172,294	\$3,212,454

Footnotes:

Total equal service totals from table 2. Administrative dollars are not reflected here.

The prevention dollars are for the Department's court diversion program. This is a program where a client on trial is assessed and vendor will work with the courts to recommend treatment rather than incarceration?

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$3,786,021
2 . Substance Abuse Primary Prevention	\$3,386,093
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	\$377,480
6. Total	\$7,549,594

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planned expenditures consistent with total for SA Block grant.

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	\$250,048
	Selective	
	Indicated	
	Unspecified	
	Total	\$250,048
Education	Universal	\$154,306
	Selective	\$18,561
	Indicated	
	Unspecified	
	Total	\$172,867
Alternatives	Universal	
	Selective	\$63,394
	Indicated	
	Unspecified	
	Total	\$63,394
Problem Identification and Referral	Universal	
	Selective	\$1,578,772
	Indicated	
	Unspecified	
	Total	\$1,578,772

Community-Based Process	Universal	\$831,871
	Selective	
	Indicated	
	Unspecified	
	Total	\$831,871
Environmental	Universal	\$124,598
	Selective	
	Indicated	
	Unspecified	
	Total	\$124,598
Section 1926 Tobacco	Universal	\$15,966
	Selective	
	Indicated	
	Unspecified	
	Total	\$15,966
Other	Universal	
	Selective	
	Indicated	
	Unspecified	\$348,577
	Total	\$348,577
Total Prevention Expenditures		\$3,386,093
Total SABG Award*		\$7,549,594
Planned Primary Prevention Percentage		44.85 %

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

Footnotes:

The totals equal planned expenditures from table 2.

The Other Unspecified category of \$348, 577 contains the Training and Technical Assistance contract \$190,000, the Evaluation contract \$71,983 and salaries/fringe that do not fit within the CSAP Strategies or IOM Targets of \$86,594.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	\$1,376,789	
Universal Indirect		
Selective	\$1,660,728	
Indicated		
Column Total	\$3,037,517	
Total SABG Award*	\$7,549,594	
Planned Primary Prevention Percentage	40.23 %	

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

Footnotes:

Total value of this form is \$3,037,517 which does not match the total on form 5a due to this form not having a line for "other unspecified" which has a value of \$348,577 for a total of \$3,386,093 which is reflected on form 5a

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

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

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$9,500	\$0	\$0	\$9,500
2. Quality Assurance	\$14,504	\$5,000	\$0	\$19,504
3. Training (Post-Employment)	\$38,000	\$0	\$0	\$38,000
4. Education (Pre-Employment)	\$0	\$0	\$0	
5. Program Development	\$133,000	\$54,166	\$0	\$187,166
6. Research and Evaluation	\$71,983	\$0	\$0	\$71,983
7. Information Systems	\$20,016	\$0	\$0	\$20,016
8. Total	\$287,003	\$59,166		\$346,169

Footnotes:

These expenditures are reflected in table 2 SA treatment column. (corrected footnote)

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	\$73,947
MHA Administration	\$16,961
MHA Data Collection/Reporting	\$95,669
MHA Activities Other Than Those Above	\$81,762
Total Non-Direct Services	\$268339
Comments on Data: <input type="text"/>	

Footnotes:
the primary prevention dollars have been reallocated per your instructions.

Revision Request-Council composition

The Governor's Council on Behavioral Health has representation from the Division of Vocational Rehabilitation in the person of the Department of Human Services representative. DHS includes the divisions of Vocational Rehabilitation and Medicaid.

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁶ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁷ It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions.²⁸ Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The [Framingham Heart Study](#) produced the idea of “risk factors” and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence-based practices^{29 30} that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.³¹ Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.³² In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.³³ Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.³⁴ Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.³⁵ In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³⁶

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³⁷ Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.³⁸ Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁹ and ACOs⁴⁰ may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.⁴¹ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.⁴²

One key population of concern is persons who are dually eligible for Medicare and Medicaid.⁴³ Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.⁴⁴ SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.⁴⁵ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.⁴⁶ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.⁴⁷ It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.⁴⁸

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁵⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.⁵¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
 - Regular screening with a carbon monoxide (CO) monitor
 - Smoking cessation classes
 - Quit Helplines/Peer supports
 - Others _____
11. The behavioral health providers screen and refer for:
 - Prevention and wellness education;
 - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
 - Recovery supports

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

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³² Depression and Diabetes, NIMH, <http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5>; Diabetes Care for Clients in Behavioral Health Treatment, Oct. 2013, SAMHSA, <http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780>

³³ J Pollock et al., Mental Disorder or Medical Disorder? Clues for Differential Diagnosis and Treatment Planning, *Journal of Clinical Psychology Practice*, 2011 (2) 33-40

³⁴ C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, *Diabetes Care*, 2010; 33(5) 1061-1064

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³⁶ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011,

http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges*. Baltimore, MD: The Hilltop Institute, UMBC.

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³⁸ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health> State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice---telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

³⁹ Health homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

⁴⁰ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

⁴¹ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS

⁴² What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

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⁴⁵ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

⁴⁶ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014;71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013;70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

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Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Integrated Health:

INTEGRATION

The following is an example of the integration of health and behavioral healthcare through the Opioid Treatment Health Home:

The Rhode Island Opioid Treatment Programs Health Home services were approved by the Centers for Medicare and Medicaid Services (CMS) in November of 2013. With almost two years of experience in coordinating care and focusing on health outcomes in the vulnerable population of opioid addicted patients, our Opioid Treatment Programs (OTP) are poised to offer state-wide integration of physical and behavioral healthcare not available in any other state. Health Home teams consist of physicians, nurses, case managers and pharmacists. Services cover the six health home domains required by CMS including care coordination, case management, health promotion, referral, family engagement, and comprehensive transitional care/follow-up. Results to date have been promising, with reductions in Emergency Department utilization, hospitalizations and nursing home placements. Surveys and focus groups have indicated increased patient and staff satisfaction. OTP programs are able to use regular contact with clients to monitor blood pressure, BMIs, diabetes management and medication monitoring.

BHDDH has been very active in the approval and implementation of Health Homes in the Community Mental Health Centers, and in the development of a State Plan Amendment for Opioid Treatment Providers to become Health Home service providers. BHDDH has worked with the State Medicaid Office, the provider networks, consumer groups, trade associations, managed care organizations, and hospitals to develop, implement and monitor these systems for integrated care.

BHDDH has met with the Patient Centered Medical Homes developed through the Rhode Island Chronic Care Sustainability Initiative to discuss integration of Behavioral Health including substance use disorders.

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?

Rhode Island's Medicaid system is funded through an 1115 Waiver. This allows the State great flexibility to fund innovative service models, which allows Rhode Island to cover most of the services listed in chart 3.

2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

There is no issue with access to outpatient services. Medicaid funds a robust array of service for substance use disorders. BHDDH monitors/audits our licensed providers to ensure they are in compliance with our regulations. BHDDH meets with Medicaid to review the benefit packages and determine where there are needs and gaps in the system of care. An example of this is Peer Supports. The Department identified this need and worked collaboratively with the Division of Medicaid to seek approval from the Center for Medicaid Services to add this services as a Medicaid reimbursable services. The Department receives information on access to treatment and length of stay issue through

incident reporting, and monitors and reviews cases with the Drug and Alcohol Treatment Association (DATA), the Medicaid Division's Behavioral Health's unit and the managed care plans.

3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.

A combination of staff from the Division of Behavioral Healthcare (DBH) and Medicaid monitors access to services from the managed care plans, receives quarterly data from the plans regarding denials and appeals and there are meetings on a regular basis with 4 parties (DATA, DBH, Medicaid and the MC plans) to review issues related to access to services.

4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?

There have been no claims to date on complaints or violations of the MHPAEA. BHDDH has established a good working relationship with Office of the Health Insurance Commissioner (OHIC) and when and if there are complaints or violations BHDDH will be involved in the resolution process.

5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

No changes are needed because the EHB's is the same package as Medicaid.

6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?

BHDDH is the SSA and the SMHA and is involved in all state coordinated care initiatives, including: State Innovations Model, HICPAC, CTC, Health Home redesign and OPT Health Homes. Integration and care coordination is one of our Department's five focal points and senior staff from the Treatment and Mental Health units, Policy and Planning, Research, Evaluation and Data and the Executive Division play critical roles in the inter-agency work groups.

BHDDH has been working closely with the Executive Office of Health and Human Services (EOHHS) and the Rhode Island Quality Institute to develop processes whereby behavioral healthcare information can be shared using the State's Health Information Exchange – CurrentCare. Use of health information technology to improve care coordination is very important to the Department. In addition, providers have been trained to be viewers of information stored in the HIE, allowing them to better plan and coordinate care.

Two of our Community Mental Health Organizations were recipients of grants to integrate physical and behavioral health—The Providence Center and The Kent Center. One program uses bidirectional co-location to deliver integrated services; the other has opened a primary care practice on site.

7. Does the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?

The Department is working closely with primary care organizations and associations to enhance relationships between FQHCs and community health centers. Most of this work has been done through the previously discussed state initiatives as well as the SPMI and OTP health home and collaborations with Department of Health especially concerning opioid overdose.

BHDDH recently hosted a State Dialogue Day to bring together providers, consumers, other state Departments and primary care practices, to have discussions with representatives from SAMHSA-HRSA – CIHS and NASMHPD, around integration efforts and directions.

RI's Health Homes initiatives have provided an opportunity to engage primary care organizations and FQHCs on a provider level. Many of our FQHCs are also Behavioral Healthcare providers licensed by BHDDH. We currently have regular interactions with hospitals to foster communication with community behavioral healthcare providers.

8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?

Some of the BHOs are addressing nicotine dependence at the same level as other substance use disorders, however, not all. Some of the BHO are offering nicotine cessation programs.

RI recognizes the need to treat nicotine dependence as a substance use disorder and has made some progress in incorporating tobacco cessation into the array of services provided by behavioral health and other healthcare facilities. In doing so, RI has experienced challenges related both to providers' historical reluctance to address nicotine addiction in behavioral health populations and to RI-specific regulations regarding insurance coverage for cessation services.

Provider-Based Initiatives

At the provider level, several BHDH-licensed service providers and FQHC's have incorporated smoking cessation into their treatment services. Primary among them are CODAC, Thundermist Health Center and Providence Health Centers. All CODAC opioid outpatient treatment programs in RI have been designated as Health Homes for Medicaid patients. CODAC was the first behavioral health agency in the State to become a tobacco free agency with cessation services offered to all clients and staff. CODAC has taken the lead in obtaining ATTUD certification for their employees and three CODAC employees are certified as ATTUD trainers.

The Department of Health provided funding for CTTS's to provide cessation for residents of public housing sites as part of a CDC-funded initiative to establish smoke-free policies

at all public housing sites in the State. Funding was available from 2012 through March, 2015. As funding ended and cessation became a covered benefit under the Affordable Care Act, public housing sites, public housing authorities are being encouraged to refer their residents to their insurance carriers for cessation services. Similarly, Providence Health Centers, who previously received DOH funding for cessation services offered to Health Center patients are providing such services through their insurer.

BHDDH currently is in the process of developing performance indicators for a value-based purchasing methodology for the State's behavioral healthcare system. These indicators will be tied to incentives offered to behavioral health providers by the managed care plans. One such indicator being negotiated is the proportion of clients reporting current tobacco use who receive cessation treatment or referral to treatment. The initial baseline measure may be a report of the number and proportion of clients by provider identified as current smokers through a required intake assessment.

Interagency Collaboration

Because BHDDH is the SSA for behavioral health and the RI Department of Health (DOH) is the state CDC-designated tobacco control entity, the sister agencies coordinate efforts to promote systems level change to increase availability and access to cessation services by individuals with behavioral health disorders. BHDDH also works collaboratively with other State agencies and community agencies and organizations on initiatives related to cessation. BHDDH staff participate on several statewide committees which address cessation including the State Task Force on Preterm Birth and the State Smoking Cessation Policy Workgroup.

RI Task Force on Preterm Birth was established in 2006 to address an increase in the State's preterm birth rate. The Task Force is led by DOH, Women & Infants Hospital and March of Dimes RI. The Task Force identified ten recommendations and assigned workgroups for each of the recommendations with the overall goal of reducing the preterm birth rate and reducing the morbidity and mortality associated with preterm birth. In 2010, an expanded Task Force was convened to assess progress and to reevaluate the initial recommendations. BHDDH participated on the workgroups targeting tobacco use by pregnant women and women of childbearing age and women with behavioral health disorders.

To date, the cessation workgroup has focused on expanding the availability of cessation services to pregnant smokers through referrals to the QuitWorks RI program and the RI Quit Line; to support evidence-based cessation services for pregnant women and women of childbearing age at state-licensed and other behavioral health agencies; and to support adoption of smoke-free environments at behavioral health agencies. For all pregnant women identified with behavioral health disorders, the focus of the workgroup is to increase the number of individuals successfully engaged in treatment services.

In 2014, the workgroup conducted a survey of twelve treatment agencies in the State to assess their smoking policies, availability of cessation services, and status as a smoke-

free agency. The agencies were selected based on their provision of services targeting pregnant women and women of childbearing age. Survey results showed significant variances among agencies in terms of adherence to required smoke free policies and the provision of tobacco cessation services to clients and agency staff. The survey results will inform efforts to increase the availability of services for the target population. BHDDH also works with licensed agencies to ensure that smoke free policies are in place and enforced.

BHDDH, in collaboration with March of Dimes RI, developed a sign depicting the dangers of tobacco use, especially by pregnant women, which included the number for the State Quit Line. All tobacco retailers in the State are required by statute to post this sign at all cash registers. The sign is available on the BHDDH website for reproduction.

In 2015, the Task Force determined that several of the initial recommendations and the strategies associated with those recommendations overlapped and subsequently restructured the workgroups to reflect the new framework for the state plan. BHDDH currently participates on the newly-created “Social Determinants” workgroup which addresses substance use, mental health and tobacco use by pregnant women and women of childbearing age.

The State Smoking Cessation Policy Workgroup is comprised of representatives from BHDDH, DOH, and community service providers, including BHDDH-licensed agencies and FQHC’s. The overall goal of this workgroup is to increase availability and accessibility of cessation services statewide. The objectives include addressing issues related to insurance coverage of cessation services, expanding workforce capacity to provide evidence-based cessation services, and increasing integration of cessation services in primary care and behavioral health services.

RI has a statute in place requiring private health insurance providers to provide comprehensive cessation coverage. Insurance providers are required to file annual compliance reports with DOH. The regulations which resulted from passage of the legislation require cessation services to be provided either by a physician or by a “tobacco treatment specialist” through physician referral. The regulations do not define “tobacco treatment specialist.” Lack of specificity in defining a tobacco treatment specialist has reduced the potential impact of the statute in making cessation services available to individuals with mental health and substance use disorders as questions regarding service reimbursement eligibility currently are unresolved. Agencies have shown some reluctance in providing services without certainty that these services are eligible for reimbursement under existing insurance plans.

Workforce Development

As RI works to resolve insurance coverage issues, efforts are ongoing to ensure that tobacco cessation services are incorporated into treatment services provided by behavioral health service providers. DOH is supporting efforts to increase the number of providers in the State employing individuals who have received ATTUD (Association for

the Treatment of Tobacco Use and Dependency) certification as Tobacco Treatment Specialists and to make CTTS's available to FQHC's as well as to behavioral health service providers. Currently, there are seven active CTTS's in the State. Recently, an additional 15 individuals began the certification process, including six representing two behavioral health providers, one representing a FQHC and another representing the State's primary service provider for homeless individuals. Training was provided by master's level ATTUD-certified trainers who are employed by CODAC, RI's largest addiction treatment provider.

In addition to this initiative, BHDDH is working with the RI Certification Board to establish a tobacco treatment endorsement to existing IC&RC-recognized treatment certifications. Training in support of the endorsement would be provided through the Department's training contract. Providers would then have two certification options available to them to ensure that cessation services are provided by qualified counselors.

BHDDH also is planning to develop cessation support training for individuals certified as Peer Support Specialists and has included cessation in the services which will be made available to individuals participating in the Healthy Transitions grant, a cooperative grant between BHDDH and the RI Department of Children, Youth and Families.

9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

All health homes and community mental health centers are required to screen, assess and refer to address nicotine dependence. Screening is required among all licensed agencies but they are not required to assess and refer. Some offer smoking cessation programs.

All agencies licensed by BHDDH are required to assess smoking status on initial client assessment. The availability of cessation services is agency-dependent as BHDDH currently does not require licensed agencies to provide cessation services or to make referrals to such services.

10. Indicate tools and strategies used that support efforts to address nicotine cessation.

- *Regular screening with a carbon monoxide (CO) monitor*
- *Smoking cessation classes*
- *Quit Helplines/Peer supports*
- *Others _____*

CO monitors were provided to all FQHC's in the State by DOH through CDC funding to the Tobacco Control Program. At present, overall frequency of usage by these agencies is unknown. CODAC and one FQHC which employ CTTS's use them on a regular basis.

The extent to which smoking cessation classes are provided in the State is unknown at this time. Several SAPT Block Grant-funded community prevention coalitions offer cessation classes, primarily focusing on youth and young adults. Cessation classes also are offered by student assistance counselors as part of SAPTBG-funded Project SUCCESS. In addition, a certified TTS employed by Project LINK at Women & Infants

Hospital has, on a volunteer basis, offered cessation classes at SSTARBIRTH, the State's residential treatment program for pregnant women and women with young children.

Department of Health manages the State's primary quit helpline called "1-800-Quit-Now." Callers to the helpline receive at least one counseling call and callers from priority populations are offered five counseling calls with a follow-up phone call and a starter supply of NRT as supplies last. QuitWorks RI is an adjunct program to the Quitline which permits health care providers to make patient referrals directly to the Quitline. DOH recently received funding to focus efforts on promoting health systems change to incorporate tobacco prevention and cessation; to expand insurance coverage and utilization of proven cessation treatments; and to support the Quitline capacity. A primary objective is to strengthen and expand linkages between health service providers (including hospitals, FQHCs and provider offices) and cessation services through provider referrals to the Quitline. As a result of a recent project funded by ASTHO, DOH established a standardized protocol to improve the referral process called the Community Health Network Centralized Referral System. DOH will implement this protocol over the next five years focusing on FQHCs and other providers serving populations disproportionately impacted by tobacco use including individuals with mental health, developmental disabilities, and substance use disorders.

11. The behavioral health providers screen and refer for:

- *Prevention and wellness education;*
- *Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,*
- *Recovery supports.*

BHOs refer individuals to prevention and wellness education through the Health Homes. The SIM initiative is focusing on health risk factors such as heart disease, hypertension, high cholesterol and diabetes. Not all agencies have recovery supports. Some of our Behavioral Healthcare providers directly offer smoking cessation programs. Others provide this resource through referral.

All behavioral healthcare providers are required by regulation to inquire about tobacco use at assessment. This information is reported to the State using the Rhode Island Behavioral Healthcare Online Database (RIBHOLD). Any changes in condition during treatment, including use of tobacco are noted in updates or at discharge. Should a client identify a desire to stop smoking, this must be added to the treatment plan and services arranged for directly or through referral. This assessment is the only screening tool – treatment tools to address smoking cessation goals are based on best practices and include the use of nicotine replacement.

All behavioral healthcare providers are required to ask health related questions at assessment, along with treating physicians, medications and family histories. Depending on the type of provider, there may be an onsite physical conducted (such as in opioid treatment programs and inpatient detoxification settings) or screenings done by a nurse (in community mental health organizations). Residential facilities are required to obtain a physical within 7 days of admission for all patients. Coordination of care is a regulatory

and contractual requirement and providers are expected to request relevant information and documentation from other treatment providers.

Providers make referrals to healthcare providers on a regular basis. Many providers have also been trained on the use of the referral form for the RI Department of Health's Chronic Condition Self-Management Education Programs – and the availability of these (often free) programs that address: diabetes; arthritis; cardiovascular disease; asthma; chronic pain; mental illness; smoking cessation; and falls prevention.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁵², [Healthy People, 2020](#)⁵³, [National Stakeholder Strategy for Achieving Health Equity](#)⁵⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).⁵⁵

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

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁵⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.⁵⁷ This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.⁵⁸ In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

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

⁵²http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵³<http://www.healthypeople.gov/2020/default.aspx>

⁵⁴<http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁵⁵<http://www.ThinkCulturalHealth.hhs.gov>

⁵⁶http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁷<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵⁸http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Health Disparities

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?

RI tracks enrollment in services by race, ethnicity, gender and age. Currently RI does not collect data on an individual's LGBT status although we plan to include this with the implementation of a new system. We also collect data on broad categories of services and can cross data with Medicaid claims data to get at specific services when they are not bundled. We do not collect data on language services, however, this information is tracked by the Executive Office of Health and Human Services through the Managed Care contracts.

2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.

DCYF - The FCCP services provide preventive and support services for children, youth and families who may not have the resources or access to help that otherwise might be open to DCYF.

BHDDH is in the process of creating a plan for ensuring disparities are addressed and reduced through access to services, service use and outcomes. BHDDH currently covers the state through contracts and uses data to determine "hot spots" for services.

3. Are linguistic disparities/language barriers identified, monitored, and addressed?

DCYF-Linguistic disparities/language barriers are identified, monitored and addresses in staffing for DCYF and the community services such as FCCPs, Parent supported agencies, and the providers of evidence based services for DCYF involved children and youth. Agency Intake forms in other languages are available in some of the community agencies along with other resources.

EOHHS tracks, monitor and address barriers.

4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.

DCYF has five vendors available for translation and interpretation services, 24 hours a day, 7 days a week. Community providers for DCYf have in house staff and various other translation and interpretation resource available to assist in providing information and services to parents in other languages. Cultural and linguistic competency training is provided by many of our community providers and by training offered to DCYF staff and community providers by the Child Welfare institute.

The **EOHHS** contracts with Managed Care Organizations and **BHDDH** contracts with licensed providers to ensure translation and interpretation services are available.

5. Is there state support for cultural and linguistic competency training for providers?

BHDDH provides training in these areas through its training contract with the Rhode Island Council of Community Mental Health Organizations (RICCMHO) for mental health and substance use disorders, as well as the prevention providers. In addition, individuals CMHOs and other BHOs provide cultural competency trainings for their staff. The Department is working with the ATTC to develop a plan to ensure it is addressing cultural competencies.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP⁵⁹ is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁶⁰, The New Freedom Commission on Mental Health⁶¹, the IOM⁶², and the NQF.⁶³ The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁶⁴ SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)⁶⁵ are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)⁶⁶ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
 - a. Leadership support, including investment of human and financial resources.
 - b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c. Use of financial incentives to drive quality.

- d. Provider involvement in planning value-based purchasing.
- e. Gained consensus on the use of accurate and reliable measures of quality.
- f. Quality measures focus on consumer outcomes rather than care processes.
- g. Development of strategies to educate consumers and empower them to select quality services.
- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

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

⁵⁹ [Ibid, 47, p. 41](#)

⁶⁰ United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁶¹ The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁶² Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

⁶³ National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁶⁴ <http://psychiatryonline.org/>

⁶⁵ <http://store.samhsa.gov>

⁶⁶ <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical Assistance needed:

1. Establishing multi-purpose EBP work groups (prevention, substance use disorder and mental health)
2. Establishing value based purchasing system and evaluating its effects.
3. Value based contracts and financial incentives.
4. Empowering consumers to select quality services.

Footnotes:

Use of Evidence in Purchasing Decisions

1. *Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.*

BHDDH - An independently licensed clinical BHDDH staff member consistently reviews the NREPP and other websites and disseminates information to our BH provider network regarding use of evidence-based or promising practices. This staff member is responsible for oversight of informational, fidelity focused, and skill based EBP trainings as part of our Workforce Development initiative, and oversees planning activities and our contracts with training entities.

Another BHDDH staff member provides training at the Rhode Council for Community Mental Health Organizations for the case management certification program. This staff person also has primary responsibility for monitoring the Health Homes initiatives and providing best practice information from other state systems.

The State Prevention Coordinator (BHDDH) manages tracking and dissemination information on evidence-based primary prevention programs and practices.

The Governor's Council on Behavioral Healthcare has an Evidence Based Practice work group focuses on the following: (1) develop guidelines for ascertaining whether a given practice, policy or program meets existing standards for evidence based practice in behavioral health; and (2) identify a process by which an innovative or locally developed behavioral health practice, policy or program can be designated as an evidence based practice in Rhode Island.

DCYF collects and disseminates information on specialized services for children, youth and families including existing evidence based practices whether funded by health insurance, state funds or other funding. This guide is available on line for use by DCYF staff and community providers. Some of the evidence based practices that are supported by Medicaid are reviewed and monitored by DCYF for compliance to Medicaid standards and quality of service and fidelity to the model. Recently, a comprehensive study of MST and outcomes was published by DCYF's data and quality control division.

2. *How information is used regarding evidence-based or promising practices in your purchasing or policy decisions?*

BHDDH staff finds it useful to weigh the risks, costs and benefits of use of a particular Evidence Based or Promising Practice while considering target population as well as agency staffing patterns and hours of operation. The Department also partners with its

sister agencies including, the Executive Office of Health and Human Services, the Division of Medicaid, the Department of Children, Youth and Families, the Department of Health, the Department of Labor and Training, the Department of Corrections and the Office of Housing and Community Development to develop and implement evidence based and promising practices to address the service, housing and employment needs of the individuals served.

DCYF is working with the Pew-MacArthur Results First Initiative to implement an innovative cost-benefit analysis approach that will assist in investing in policies and programs that are proven to work. DCYF and representatives from OMB (Office of Management and Budget) and Results First are developing an inventory of services that assist with keeping kids safe and at home, the costs associated with those activities and the resulting outcomes of those services.

DCYF has committed to supporting the development and implementation of use of evidence based practices and promising practices that have shown to be effective in addressing issues specific to prevention of mental health issues by providing early intervention and education with focus on trauma and children at risk or already diagnosed with serious mental health disorder.

3. *Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?*

BHDDH is working closely with the Division of Medicaid, EOHHS, the Department the Health and the Office of the Health Commissioner through the State Innovations Model grant to develop an integrated health and behavioral health plan. The agencies are including best practices and evidence based practices whenever possible.

4. *Does the state use a rigorous evaluation process to assess emerging and promising practices?*

The Governor's Council on Behavioral Health, the planning body for the Mental Health and Substance Abuse Block Grant, has developed an Evidence Based Practice work group that guides the state's initiatives. The work group began its focus in the area of prevention, however, is being expanded to include substance use and mental health. The enhanced capacity of this work group to address evidence based and promising practices in these areas assists the state agencies in developing a systemized inventory to prioritize our collective work and guide our funding decisions across Departments. Most of our state's innovations are funded through federal discretionary grants with the hope to pilot programs that will be adopted by the state. All of our discretionary grants include an evaluation process and through this work, BHDDH is solidifying its relationships with our state college (Rhode Island College) and university (University of Rhode Island) through a Memorandum of Agreement to establish an internship program that will focus on research, data analysis, needs assessment and planning.

The State Epidemiological Outcomes Workgroup's (SEOW) mission is to institutionalize data driven planning and decision making in the areas of substance use, abuse and

consequences and mental illness. Through the efforts of the SEOW, the Governor's Council on Behavioral Healthcare is provided with a state profile to ensure planning is data driven.

5. *Which value based purchasing strategies do you use in your state:*
 - a. *Leadership support, including investment of human and financial resources.*
 - b. *Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.*
 - c. *Use of financial incentives to drive quality.*
 - d. *Provider involvement in planning value-based purchasing.*
 - e. *Gained consensus on the use of accurate and reliable measures of quality.*
 - f. *Quality measures focus on consumer outcomes rather than care processes.*
 - g. *Development of strategies to educate consumers and empower them to select quality services.*
 - h. *Creation of a corporate culture that makes quality a priority across the entire state infrastructure.*
 - i. *The state has an evaluation plan to assess the impact of its purchasing decisions*

BHDDH - In addition to information that agencies provide in their proposals, the Department determines costs and effectiveness of interventions used by analyzing outcomes data collected by the Data unit. We compared the demographic information of populations served in various modalities, treatment retention/completion rates, drugs of abuse and then identified potential best practices to address these specific concerns. RFPs provide the information on these populations and ask for programs to offer evidence based practices to meet the need. Scoring of proposals reflected programs' abilities to provide EBPs appropriate to the population – especially in women's specific treatment.

The Department received a BRASS TACS grant to develop peer support certification and the process through which the BHDDH is developing a certification program and demonstrating the philosophies of a recovery oriented system of care. The integration of peer supports into our state's programs enhance the services and choices available to the individuals who participate in the system by educating and empowering them to select better quality services.

DCYF is focusing on developing contract with outcomes and has assistance from a team from the Government Performance Lab Harvard Kennedy School. This technical assistance will help DCYF in development of results-driven contracting strategies for DCYFs grants. Strategies include defining performance goals and measuring outcomes to be achieved and tying payments to successful outcomes, and using performance data to inform contract decisions.

Technical Assistance needed:

- 1. Establishing multi-purpose EBP work groups (prevention, substance use disorder and mental health)**
- 2. Establishing value based purchasing system and evaluating its effects.**
- 3. Value based contracts and financial incentives.**
- 4. Empowering consumers to select quality services.**

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

SIMs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.⁶⁷ The “Prodromal Period” is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.⁶⁸ In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.⁶⁹ The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.^{70 71} This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

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

⁶⁷ Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

⁶⁸ Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

⁶⁹ Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

⁷⁰ van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

⁷¹ McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

1. Target pop and diagnostic category

RI has selected youth and young adults ages 16-25 with serious mental illness as the population of focus for the set-aside funds. According to the 2012/2013 NSDUH, 11.32% of RI's 12-17 year olds and 9.74% of 18-25 year olds reported at least one major depressive episode in the past year. Among 18-25 year olds in RI, 4.47% report a serious mental illness in the past year; 19.93% report any mental illness and 7.34% had serious thoughts of suicide.

In 2011 approximately 4,000 9th – 12th graders participated in the Rhode Island High School Risk Behavior Survey. The findings demonstrated that nearly 25% of students “felt sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.” Over 14% reported more than one suicide attempt; Hispanic/Latino Youth reported a rate 9-10% higher than other ethnicities.

Claim data from the Medicaid Management Information System (MMIS) for State Fiscal year 2014 identified 10,484 unique recipients ages 16-25 who incurred a claim having a primary diagnoses in the range of Mental Disorders. The most prevalent primary diagnosis was for Episodic Mood Disorder at 30.7% of the recipients, followed by Anxiety/Dissociative/Somatoform Disorders at 28%. Additionally there were 3,521 unique recipients, ages 16-25, who incurred a claim having a "Serious" Mental Disorder as a primary diagnosis. The most prevalent primary diagnosis in this range was for Episodic Mood Disorder at 91.4% of the recipients, followed by Other Non-Organic Psychoses at 12.8. Of the 3,217 recipients who incurred a claim having an Episodic Mood Disorder, 36.8% were Major Depressive Disorder, recurrent.

Since FEP numbers within the state are small, our population of focus are individuals, 16-25 with the following diagnoses: Bipolar Disorders, Major Depressive Disorders, Generalized Anxiety Disorders, Post-Traumatic Stress Disorder, Schizophrenic Disorder (Schizophrenia Spectrum & Other psychotic Disorders –DSM5), Dissociative Identity Disorder and Depersonalization/Derealization Disorder.

2. EBP

In September of 2014, Rhode Island received a Healthy Transitions (HT) grant. The purpose of the grant is to improve access to treatment and support services for 16-25 year olds with, or at risk for developing, serious mental illness. The cities of Woonsocket and Warwick were chosen as the local laboratory sites to implement an evidence-based practice appropriate for this age group. These communities were chosen due to their supporting local infrastructures and community readiness to plan and implement a comprehensive model.

The evidence-based practice selected is Coordinated Specialty Care (CSC), specifically the OnTrack NY-Connection adaptation. The reason for selection is its success in engaging and treating individuals in this age group experiencing a first episode psychosis (FEP). Funding from HT allows the creation of one CSC treatment team in each of the two community laboratories: Community Care Alliance in Woonsocket and The Kent Center in Warwick.

We are currently using the set-aside funds to consult with and receive training from the Center for Practice Innovations (CPI) at the Research Foundation for Mental Hygiene on implementation of the OnTrackNY- Connection approach of the CSC. That model has been modified slightly to include staff time for outreach and evaluation for eligibility. On March 13, 2015, over 50 behavioral health workers throughout the state participated in an introductory training in Early Identification and Treatment of Psychosis among Young Adults using the CSC model. In August of 2015, CPI conducted a 3 day role specific training for staff working on the two CSC treatment teams funded through the Healthy Transitions grant and conducted a 2 hour remote session for doctors participating on the teams. HT CSC teams will begin providing services in September 2015.

3. Use of Set-aside Funds

A technical assistance visit for the Healthy Transitions grant occurred in June of 2015 and emphasized the role of peer supports in working with young adults. Peers are able to provide a unique perspective to those with similar life issues by offering insights and support into the recovery process based on their own experience. We plan to use this year's set aside funds to enhance our service model with peer support services. We deliberately delayed the introduction of peer services into our implementation because we currently lack expertise with respect to this age group. Our plan is to staff a full time Peer Coordinator in each of the two Healthy Transition service sites. Peer Coordinators will work as a part of the CSC team providing direct peer support to CSC participants. They will serve a different role on the team from the Substance Abuse Clinician in that they are not Master's level and/or licensed clinicians. Rather they are para- professionals with a willingness to share their personal stories and offer their support to promote socialization, long-term recovery, wellness, self-advocacy, development of natural supports, relapse prevention, and community inclusion. These individuals will participate in a new core training and pursue certification as Peer Recovery Specialists which has recently become available through the RI Certification Board.

The Peer Coordinators will also work in collaboration with other ongoing statewide efforts such as the RI BRSS TACS Policy Academy to identify/develop additional age appropriate training and services that will help address the specific needs of youth and young adults. They will be instrumental in helping to develop a continuum of peer supports. Depending on their stage of readiness, a peer can provide a variety of services ranging from developing communication plans and materials, engagement efforts, system change and provide 1:1 services in clinical or community settings. In addition to providing 1:1 services in the Healthy Transition sites, our Peer Coordinators will recruit new peers and support them as they individually transition over the seven stages beginning with self-advocacy to becoming supportive adults.

4. Data collection

Since award of the Healthy Transitions grant, BHDDH in cooperation with DCYF, the local community labs and the Evaluator have developed a strategy for screening and assessment of participants to be served. Tools for this were identified and a decision tree developed for determining eligibility. The local labs have also established agreements with community partners to conduct screening and make referrals.

Each of the two Healthy Transitions CSC teams will be expected to screen a minimum of 250 individuals per year of which 100 will receive clinical assessments and 50 comprehensive services. All participants will complete a baseline interview, and follow up interviews every six months that they are receiving services. The interviews will measure functioning in school, home and daily life; relationships with family members; emotional and behavioral status; vocational and education status; stability in housing; criminal or juvenile justice status and perception of care.

A great deal of attention has also been given to adapting data systems to accommodate the required SAMHSA participant level data collected through the baseline and follow up interviews. Toward this end, the local labs have conducted cross walks of the data currently collected from their clients with the new SAMHSA data collection instrument and are modifying their Electronic Health Records in order to automate client level data reporting to SAMHSA's Common Data Platform. BHDDH is also creating its own data base to hold the screening data that is collected.

Fidelity requirements related to the CSC will include performance expectations related to the team's structure and functioning, psychopharmacology intervention, clinical services, working with families, education and employment support.

In addition to the data collection components directly related to the implementation of the CSC evidence-based practice, there is data collection systems being developed for Peer Recovery Specialists and consumers through the BRSS TACS Policy Academy initiative. There are two data collection systems being designed:

- a data collection system to better understand outcomes associated with *consumers* seeking assistance from a peer recovery specialist.
- a data collection system to better understand outcomes associated with *peer recovery specialists* working within Rhode Island's recovery-oriented system of care for substance use and mental health services.

We envision accessing this data as another way to measure outcomes related to this practice particularly the peer component.

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.⁷² SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded [Recovery After an Initial Schizophrenia Episode \(RAISE\) initiative](#)⁷³, a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

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

⁷² <http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf>

⁷³ http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Original Narrative for Prevention of SMI

1. Target pop and diagnostic category

RI has selected youth and young adults ages 16-25 with serious mental illness as the population of focus for the set-aside funds. According to the 2012/2013 NSDUH, 11.32% of RI's 12-17 year olds and 9.74% of 18-25 year olds reported at least one major depressive episode in the past year. Among 18-25 year olds in RI, 4.47% report a serious mental illness in the past year; 19.93% report any mental illness and 7.34% had serious thoughts of suicide.

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Additional information for Revision Request:

Rhode Island will be using the 5% set aside for SMI prevention to enhance its two Healthy Transitions grant-funded CSC local programs. It will do that by hiring, training and assigning a Young Adult Peer Support staff person to work as part of the two CSC treatment teams and to support youth/young adult practice competencies in the two CSC programs. As soon as the Block Grant Notice of Award is received, it will be able to amend its contracts with the two local

CSC programs to include the new activity, and at that point, a budget can be developed. The full 5% will go to this use. The following is the draft Scope of Work for these contracts:

RI Scope of work: 5% set aside

Defining Role of Young Adult Peer

The Young Adult Peer support role is designed for individuals with personal, lived experience in their own recovery and wellness. Young Adult Peer Support Services are essential elements in developing a system of care unique to young adults of transition age youth and young adults. Young Adults Peers offer insight into the wellness and recovery process based on their own experience and are able to provide a unique perspective to those experiencing similar life issues. The role of the Young Adult Peer support reflects a collaborative and strengths-based approach, with the primary goal being to assist individuals and family members in achieving sustained recovery from the effects of addiction and/or mental health issues. Young Adult Peers are not clinicians; they serve in a supportive role within the community and/or treatment setting. They do not replace other professional services; they complement the existing array of support services. The Young Adult Peer is not a sponsor, case manager or a therapist but rather a role model, mentor, advocate and motivator.

General Requirements

Hire a Young Adult who demonstrates readiness to serve in a leadership role to support the local Healthy Transitions learning lab in the development of a strong young adult driven program and establish peer to peer supports for young adults who participate in NITT-HT programing. The Young Adult hired must:

- a) Be willing to utilize and share personal experiences related to wellness and recovery to build connections with others who are working on their own recovery and wellness. Young Adult Peer will*
- b) Support the provider network to ensure services and support are young adult driven through serving as a resource to treatment teams and participate in case consultation and or supervision when appropriate.*
- c) Ensure that all service delivery activities, including engagement strategies, are culturally and developmentally appropriate for young adult driven programing.*
- d) Participate in meetings with the Healthy Transitions State Youth Coordinator and Project Director as required*

Required Tasks and Activities

- 1. Outreach, engagement and referral-*
- 2. Community Awareness-*
- 3. Treatment Planning- Participate in a consultation role to Wraparound, TIP facilitators to assure program is young adult driven, support in resource linkages and integrate community based local programing into individualized treatment planning.*
- 4. Wellness & Recovery Planning- Facilitate wellness groups (i.e. Wellness Action Recovery Planning, Whole Health Action Management) for young adults who are involved with the mental health system and are enrolled within the formalized service array.*
- 5. Life Skills Programs – Identify, develop and implement community based skill building activities that enhance formalized treatment services for those enrolled in Wraparound such*

- Life Skills topics include but are not limited to financial literacy, abusive relationships, accessing subsidized housing, etc.*
- 6. Young Adult Engagement- Establish and convene a local young adult advisory/ wellness council that allows young adults meaningful roles in advising local efforts in learning labs and establishes non- traditional programs that support recovery and build self- efficacy outside of treatment session.*
 - 7. Needs Assessment - Conduct a local needs assessment to better understanding service and gaps in programing unique to young adults of transition age who are struggling with or at risk of mental health challenges.*

Deliverables

- 1. Submit program progress notes in a format determined by BHDDH and DCYF. Reports will be Submitted Monthly during the first and quarterly thereafter*
- 2. Within 30 days of contract, develop a plan for youth and young adult peer programing which include the policies and practice guidelines needed to hire and support a young adult with lived experience on the leadership team for the local learning lab.*
- 3. Within six months of hire the young adult peer will complete the required learning objectives to become a RI Certified Peer Recovery Specialist.*
- 4. Deliver a minimum of two life skills opportunities per quarter.*
- 5. Within three months of hire conduct local needs assessment of service gaps*

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them through the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Participant Directed Care

The Rhode Island Consumer System of Care is a service option that is part of BHDDH's regulations. It is a recovery –focused model that allows consumers to receive individualized care selected from a menu of services provided by licensed behavioral health organizations. The model consists of empowering individuals and families to participate in treatment and access to the necessary services to meet their treatment needs. Individuals are provided with levels of care in response to clinical needs and presentation. It is expected that individuals will transition between levels of care in response to progress in recovery, attainment of goals and client choice.

The Executive Office of Health and Human Services is leading the Home and Community Based Services (HCBS) planning process to create a person-centered, community-based integrated services plan that will bring the state into compliance with the HCBS Rule by 2019. BHDDH is participating in this process for individuals with developmental disabilities who receive services through the HCBS-like waiver. The Division of Behavioral Healthcare is planning to align its regulations, policies and protocol to adopt the principles.

Through an Access to Recovery grant, the Division piloted a voucher program that provided individuals with a service voucher based on an assessment. The individuals participating in the program were able to choose their service provider. This program provided client choice and was a great example of self-directed care. BHDDH applied for, but did not get, an ATR-4 grant, and no state funds were available to continue the program. However, the Division continues to review “lessons learned” from this program and continues to consider ways to fund this program.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x- 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse 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 SABG and MHBG. 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 substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required 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 consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Client level encounter/use/performance analysis data; and
 - f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Program Integrity

BHDDH does not have a specific Program Integrity Plan, but will only use block grant funds to provide services that are not covered by Medicaid and/or private insurance.

Providers will be required to determine if an individual has applied for coverage through the web-based portal prior to providing any services that may be funded through the block grant. Such an application is a requirement for an individual to receive block grant funded treatment. BHDDH routinely monitors program utilization, billing and regulatory compliance. Some of this integrity function is accomplished through regular audits and incident/complain investigations.

The Administrator of Behavioral Healthcare is the specific staff person that has primary responsibility for BHDDH's program integrity activities.

To monitor the appropriate use of Block Grant funds, BHDDH uses the following monitoring and oversight practices:

- a. Budget review;
- b. Claims/payment adjudication;
- c. Expenditure report analysis;
- d. Compliance reviews;
- e. Encounter/utilization/performance analysis;
- f. Occurrence/incident investigations and reporting regulations
- g. Audit interviews with consumers and a Substance Abuse Prevention and Treatment Block Grant Monitoring Check list with agency management and staff.

BHDDH contracts with providers who submit successful applications through a Request for Proposals process. These contracts specify payment methodologies and deliverables for the specific services to be provided. All payments are based on either utilization or submission and approval of invoices. Payments based on utilization are determined through the Rhode Island Behavioral Health Online Database (RIBHOLD) which captures all client admission and discharge data.

All providers are required to adhere to the Rules and Regulations for Behavioral Healthcare Organizations, which includes extensive descriptions of requirements related to quality and safety standards. This compliance is monitored through routine combined licensing/clinical audits and through investigations of incidents and complaints and bi-annual reviews.

Noncompliance is noted in either response to an audit or investigation and programs are asked to submit a plan of corrections. These plans may include request for technical assistance from BHDDH to come into compliance. BHDDH meets with BH programs regularly and provides guidance in terms of meeting quality and safety standards. BHDDH also provides funding for staff training through The Substance Use and Mental Health Leadership Council of RI. (*Formerly RI Council of Community Mental Health Org. and DATA of RI, Inc.*) And the New England Institute of Addiction Studies. The legal and licensing units of BHDDH provide ongoing trainings for providers on compliance with and issues related to the Mental Health Law and RI regulations regarding licensing compliance.

All providers are currently required to check clients for active Medicaid coverage (through a centralized phone line) prior to billing BHDDH. Source of pay is a required field of the RIBHOLD system and block grant payments based on utilization will prohibit expenditures for Medicaid covered individuals. Providers will continue to be required to check for Medicaid eligibility, but in 2014, will also be required to check for an individual's application for Coverage through the UHIP portal. BHDDH is working with EOHHS to streamline this process for providers.

DCYF does not have a specific integrity plan regarding the Children's portion of the MHBG fund.

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁷⁴ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

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

⁷⁴ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factor #8 – Tribes

1. *Describe how the state has consulted with tribes in the state and how any concerns were addressed in BG*

The Executive Office of Health and Human Services and, in particular, its Medicaid and DCYF divisions have had many years of formal working relationships with the Narragansett Tribe, Rhode Island's only federally recognized tribe. The EOHHS operates under a Title XIX State Plan which is in compliance with the Tribal Consultation Requirements Section of the Social Security Act. This plan sets requirements for communication between the EOHHS and the Narragansett Tribal Chief and the Narragansett Indian Health Center around any proposed changes to the state's Medicaid program. In addition, the Tribe has been invited to participate in the following Medicaid-related committees: the Consumer Advisory Group; the Medical Care Advisory Committee; the Global Waiver Task Force; the Interested Parties Distribution List for Public Notice, Family Resource Counselor Trainings and all meetings related to Health Reform. NIHC's Medical Director, Joanne Benson, has a seat on the Medical Care Advisory Committee, staff have attended the Consumer Advisory Committee and the NIHC has an identified Family Resource Counselor at the Center. The NIHC's Medical Director maintains contact on an as-needed basis with the Medicaid State Plan Coordinator, primarily around issues of service funding and MCO benefits.

DCYF has a Cooperative Agreement with the Narragansett Indian Tribe, Tribal Child and Family Services, for a Narragansett Tribe Representative to serve as liaison to the DCYF Child Protective Services. The Tribal representative was invited to participate in the development of the Block Grant.

The Tribe has chosen not to engage in regular, formal contacts with BHDDH around treatment services.

2. *Describe current activities between the state, tribes and tribal populations*

The tribal representative may also participate in coordinating training with the DCYF staff, provide assistance with identification and documenting federally recognized Indian Tribal members and other activities as appropriate to ensure compliance with the federal Indian Child Welfare Act (ICWA).

In 2014 the Acting Chief, Antone Munroe, and Sergeant Ed McQuaide joined the Prevention Council in Chariho, RI, the site of the Narragansett Reservation. Their focus has been on law enforcement and party patrol work. In addition, Sierra Spears, a tribal member, joined the Prevention Council and is pursuing Prevention Specialist certification to provide prevention education to the Tribe. It is BHDDH's intention to explore possible contact with the NIHC around treatment-related issues with these individual.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
 - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
 - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
 - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
 - a. A statewide licensing or certification program for the substance abuse prevention workforce;
 - b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
 - c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Primary Prevention for Substance Abuse

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is the single state authority for substance abuse prevention and treatment.

State Epidemiology and Outcomes Workgroup

The State Epidemiological Outcomes Workgroup (SEOW) is administered by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), the single state authority for substance abuse prevention and treatment and the state mental health authority and reports results of its activities to the Rhode Island Governor's Council on Behavioral Health. In 2006, the SEOW was established as part of the Strategic Prevention Framework State Incentive Grant (SPF SIG), within the Executive Office of Health and Human Services (EOHHS) and was transferred from EOHHS to BHDDH in 2008. The mission of the SEOW is to institutionalize data-driven planning and decision making for the purposes of state and community level substance use, abuse, and consequences, and mental illness across the State of Rhode Island. State and community epidemiology profiles have been produced in 2006, 2009, 2013 and 2015.

The SEOW is charged with the following tasks: (1) Develop a set of key indicators, micro level to macro level, to describe the magnitude and distribution of substance use, abuse, and consequences, and mental illness as well as to develop a set of key indicators, micro level to macro level, of risk and protective factors associated with substance use, abuse, and consequences, and mental illness across the State of Rhode Island; (2) Identify, collect, manage, analyze, and interpret data on the prevalence of substance use, abuse, and consequences, and mental illness; relevant risk and protective factors at multiple ecological levels; (3) Based on these data, develop and communicate state-level and community-level epidemiologic profiles for promotion, prevention, treatment, recovery and policy implications for Rhode Island healthcare system; (4) Inform and recommend priorities for the State of Rhode Island based on the community and state-level epidemiological profile; and (5) Maintain and expand a systematic, ongoing monitoring system of the prevalence of substance use, abuse and consequences, mental illness, and relevant multilevel risk and protective factors.

The SEOW utilizes national and local data drawn from a variety of sources and include indicators of behavioral health related consequences, incidence and prevalence of substance use and mental health disorders and associated intervening variables including risk or protective factors. The data is primarily archival or survey data. Data is collected on age ranges across the lifespan, race/ethnicity, gender, sexual orientation, geography, disability and military status, although not all data sets permit this level of disaggregation. Data sources utilized by the SEOW include but are not limited to: Behavioral Risk Factor Surveillance System, Pregnancy Risk Assessment Monitoring System, Youth Risk Behavior Surveillance System, National Survey on Drug Use and Health, National Vital Statistics System, Treatment Episode Data, US Census, Fatality Analysis Reporting System, Uniform Crime Reports, US Department of Housing and

Urban Development, Bureau of Labor Statistics, RI Department of Children, Youth and Families, RI Kids Count, CDC School Health Profiles, National Survey of Children's Health, State Health Facts, RI Department of Education's Survey Works, School Accountability for Learning and Teaching, and the RI Alcohol Purchase Survey.

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 various populations (i.e., youth vs. adult);
- potential risk and protective factors associated with substance use and mental illness; and,
- mental and behavioral health outcomes across the State of Rhode Island.

The Profile contains most relevant data on statewide substance use and abuse (consumption patterns), alcohol consumption patterns, mental health, short- and long-term consequences, and risk and protective factors. Additionally, substance use and abuse, alcohol consumption patterns, and short- and long-term consequences by RI versus national averages and RI as compared to regional states including the New England and Tri-State regions. New to this Profile are more in-depth background and RI demographic context. This Profile included more data of population, age groups, specific racial and ethnic groups, foreign born and language, education, income, labor force data including unemployment rates, homelessness status, and health insurance coverage.

In addition, this Profile provided data by age group and time-trend for many of the topics presented. Keeping the inherent limitations in mind, the data summarized in the Profile can be utilized for promotion, prevention, treatment, recovery and health-care planning for 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, as well as potential risk and protective factors from all ecological levels that helped to drive the strategic planning process.

Major accomplishments for 2015 include assisting the state with drawing the sample for 2015 Alcohol Purchase Survey, updating and expanding the 2013 State and Community Epidemiology profiles, compiling a set of validated tools for qualitative data collection for the Partnership for Success communities and a guidance document for the PFS community needs assessment. Members of the SEOW also served on the review panel for the PFS community level strategic plans.

In the coming year, the SEOW will present the updated state epidemiology profile and discuss implications for behavioral health planning to the Governor's Council on Behavioral Health and

other key stakeholders across the state, analyze data from the 2015 Alcohol Purchase Survey and draw the sample for the 2016 administration, revise the needs assessment guide and refine the qualitative data collection tools included in the guide, and provide additional data to respond the SABG application.

We use several mechanisms to determine funding allocations. In 2009 State Epidemiology Profile was used to identify a priority substance to target with five year awards under the SABG primary prevention funds. RI saw significant increases in use of marijuana across the lifespan and decreases among youth in risk or harm associated with the use of marijuana. The Department made a strategic decision at the end of the funding cycle for the last set of SABG prevention awards, to create a new initiative entitled Prevention of Marijuana and Other Drugs that addressed use of marijuana and other illicit drugs by youth. In November of 2011, nine entities were funded to focus on increasing perception of risk or harm associated with use of marijuana and other drugs through a combination of educational strategies implemented in school settings and social marketing campaigns. As these 5 year awards enter their final year, the results of the 2015 State Epidemiology Profile will help us to identify a priority problem, related consumption pattern and associated risk or protective factors to target with the next 5 year round of funding.

The following recommendations have been made by the SEOW in its' draft 2015 State Epidemiology Profile. If these are adopted and endorsed by the Prevention Advisory Committee of the Governor's Council on Behavioral, they will inform the allocation strategies and priorities for next set of Requests for Proposals associated with the SABG primary prevention funds:

- Continued work in the area of health insurance coverage to reduce the 9% of Rhode Islanders still uninsured.
- Illicit drug use and marijuana use in the past month and nonmedical use of pain relievers in the past year are still a major concern to Rhode Islanders especially since prevalence rates exceed the national averages.
- Drug abuse or dependence and needing but not receiving treatment for drug use remain a concern although progress and improving trends seen for Rhode Islanders.
- Data presented on marijuana use, especially for the underage population varies and the increasing use is of great concern. Further data is needed to identify what RI could do to develop prevention, intervention, and treatment strategies.
- Black high school students in RI as compared to the US are at a higher risk of alcohol use, prescription drug abuse, cocaine use, and methamphetamine use while Asian and White high school students are at a high risk for marijuana use. Development of prevention, intervention, and treatment work is needed.
- Continued work regarding alcohol consumption in particular in the 18-25 age group is needed.
- Alcohol consumption for the underage population in particular for Black high school students is a great concern. Additionally, for all RI high school students, for initial use of alcohol before age 13 and been in a car where an individual had been drinking and

driving in the past month has improved when compared to national averages but remains a concern.

- Children in RI as compared to national averages who need mental health care do receive services and treatment; however, improvements in all mental health issues can be developed.
- The short- and long-term consequences reported in this Profile should be taken as is without causal inferences in relation to substance and alcohol use. Overall, RI as compared nationally and to regional states had higher rates across all categories reported. Further work needs to be done to determine a better picture of the relationship between substance and alcohol consumption and patterns with health outcomes.
- More work could be done to reduce the exposure of children in a school setting to illegal drugs and other substances.

One of the greatest challenges to the substance abuse prevention field in Rhode Island, as well as nationally, is the recruitment of new employees, and the retention of current ones, as our workforce ages into retirement or changes careers. BHDDH is dedicated to the recruitment, retention, education, and training of substance abuse treatment and prevention professionals and to improving the quality of our workforce. BHDDH is currently working with the New England Addiction Technology Transfer Center (ATTC-NE), the New England Institute of Addiction Studies (NEIAS), the Rhode Island Prevention Resource Center (RIPRC), the Drug and Alcohol Treatment Association (DATA), the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for the Application of Prevention Technologies (CAPT) our state colleges and universities, and other community partners to develop and implement new initiatives to support workforce development.

BHDDH has adopted the Strategic Prevention Framework (SPF) as the strategic planning approach that guides the development of state and community substance abuse prevention priorities. The SPF consists of five (5) steps:

- [assess prevention needs based on epidemiological data](#);
- [build prevention capacity](#);
- [develop a strategic plan](#);
- [implement effective community prevention programs, policies, and practices](#); and,
- [evaluate efforts for outcomes](#).

It is important to note that the SPF includes two cross-cutting principles of cultural competency and sustainability. Use of the SPF has helped to create a transparent and data guided approach to allocation of prevention resources throughout the state of RI. Prevention providers are also expected to utilize the SPF process to inform local prevention efforts and priorities.

Funding for substance abuse prevention efforts was eliminated from the state budget effective in state fiscal 2015 and as such, all substance abuse prevention activities are funded through the federal Substance Abuse Prevention and Treatment Block Grant and/or discretionary federal funding. This requires a major role for the state on increasing the ability of the prevention provider network, and its' workforce, to respond to reporting needs associated with the block grant.

UNDERSTANDING EMERGING TRENDS AND CHANGING NEEDS OF THE PREVENTION WORKFORCE

Early prevention programs often relied on unproven strategies that lacked appropriate evaluation and documentation of results. However, for more than a decade, prevention science has evolved into an ever-increasing number of evidence-based programs and practices. Current prevention programs, policies, and practices continue to evolve and support the science that drives the delivery of evidence-based approaches that address alcohol, tobacco, and other drug (ATOD) problems.

Prevention is defined as a proactive, multifaceted, multi-community-sector process involving a continuum of culturally appropriate services. It empowers individuals, families, and communities to meet the challenges of life events and transitions by creating and reinforcing conditions that have an impact on physical, social, emotional, spiritual, and cognitive well-being and promote safe and healthy behaviors and lifestyles. Substance abuse prevention is a planned sequence of activities that, through the practice and application of evidence-based programs, policies, and practices, is intended to inform, educate develop skills, alter risk behaviors, and affect environmental factors in addressing alcohol and other drug problems.

(See “An Action Plan for Behavioral Health Workforce Development, prepared by The Annapolis Coalition on the Behavioral Health Workforce (Cincinnati, Ohio) under Contract Number 280-02-0302 with SAMHSA, U.S. Department of Health and Human Services. 2007.)

The growing body of scientific knowledge and use of evidence-based programs have helped to focus prevention within the behavioral health field, but the progress has not been without challenges. These changes have placed increased demands on the workforce that include increased credentialing requirements, the availability of targeted training and skills development, and issues around pay scales.

Rhode Island has documented both strengths and weaknesses of its current substance abuse prevention and treatment system throughout its strategic plan (See *Rhode Island Amended Strategic Plan for Substance Abuse Prevention 2013-2015*). Our state action plan for an integrated system of care includes the development of a qualified workforce to meet the unique treatment and prevention needs of individuals with co-occurring disorders. This includes, but is not limited to; making sure the capacity of the workforce is level across communities. This would mean that regardless of where an individual working in the field is from, efforts are made across communities, and the State as a whole, to ensure that the workforce has the same level of competency to deliver prevention services. Opportunities exist to explore enhanced infrastructure to increase awareness and capacity among stakeholders within the system, while creating greater integration and efficiencies of the system as whole.

There is a need to have greater surveillance of current or existing providers to better understand the varying levels of readiness and capacity to affect change. A clear opportunity exists to

improve workforce development strategies to increase the capacity, knowledge, skills and organizational development of prevention and mental health promotion providers driven by sound practice and data-driven program planning. Through the implementation of our State's plan and leveraging existing opportunities within the system, this will allow RI to establish a foundation to support an evolving and on-going workforce development planning process.

One key success for Rhode Island includes its efforts to fundamentally transform its prevention infrastructure. BHDDH based this transformation, in part, upon empirical results generated from Rhode Island's SPF-SIG grant. Using data from Rhode Island community coalitions, Nargiso and colleagues (Nargiso et al., 2012) found that community coalitions which endorsed weaker mobilization, structure and task leadership utilized more Training and Technical Assistance (TTA) offered during the Strategic Prevention Framework State Incentive Grant (SPF-SIG) compared to those who perceived their coalition as having greater capacity. Moreover, communities that utilized more TTA resources produced a greater number of successful policy changes in municipal and school policies relating to underage drinking. These findings led BHDDH to fund the Rhode Island Prevention Resource Center (RIPRC) with Prevention Block Grant funds.

According to 2013 Rhode Island Youth Risk Behavior Survey (YRBS) data:

- four alcohol use measures among high school students have improved since 2007: current drinking, early drinking, binge drinking and driving and drinking;
- the prevalence of current smokers, heavy smokers and any tobacco use among high school students decreased compared to the prevalence in 2007; and,
- there was a slight increase in marijuana use compared to 2007, but a decrease in cocaine use during the same time period.

The YRBS results show a measurement of the success of TTA.

The Rhode Island Prevention Resource Center (RIPRC) is a statewide, central information sharing and training and technical assistance (TTA) resource for all Rhode Island state and community-based substance abuse prevention services and their community partners. In order to effectively target TTA resources, the RIPRC collected baseline training and technical assistance needs and organizational capacity information in the 2012. Fifty (50) organizations engaged in substance abuse prevention activities were invited to complete the TTA needs assessment survey that asked about a variety of TTA topics including: organizational capacity to build effective coalitions, monitoring and evaluation, ability to offer evidence based programs and practices, ability to implement evidence-based policies, cultural competency, understanding of the Strategic Prevention Framework, knowledge of target populations, and program management. A total of thirty-five (35) unique providers completed the needs assessment survey, a seventy percent (70%) response rate.

It is important for trainings to match workers' or workplaces' needs to meet core competencies for those in the field and to adequately meet the needs of the people they serve. The RIPRC needs assessment identified eight (8) training content areas needed to increase the capacity of

communities to implement, sustain and improve effective prevention initiatives, content areas including: Public Policy and Environmental Change (43%), Prevention Policy Development (37%), Ethics and Confidentiality (37%), Sustainability Planning (34%), Survey Development and Use (31%), Navigating Political Systems (31%), Using Survey Data for Planning and Proposals (29%) and Implementing Focus Groups (29%). The following six (6) key technical assistance needs were also identified: Increasing the Prevention Expertise of Coalition Members (49%), Maximizing Social Media Tools for Prevention (43%), Implementing and Using Needs Assessments (40%) Using Data for Program Improvement (29%), Engaging Key Stakeholders (29%) and Utilizing Asset Building Multidisciplinary Programming (26%).

RIPRC's TTA work plan and deliverables have been based on the needs assessment data and focus on an environmental approach to prevention that captures substance use and abuse, but also works to reach the complementary goals of reducing the burden of mental, emotional, and behavioral disorders and promoting healthy development of children and young people in Rhode Island. Having a findings-based work plan serves to avoid duplication of services, improve access to training opportunities for workforce development, and increase participation in the RI Substance Abuse Certification Process. Examples of activities to further impact workforce development include: to identify prevention coaching opportunities between task force members; development of a manual for new staff.

One of the primary areas of the State's strategic plan includes activities identified to increase participation in the RI Substance Abuse Prevention Certification System, while building on the current substance abuse prevention infrastructure to both expand and increase the capacity of the prevention workforce in RI. The RI Substance Abuse Prevention Certification Process is currently under-utilized. The primary benefits of certification for individuals and organizations identified by assessment participants includes: *meeting the requirements of BHDDH funding, that it documents prevention expertise, and gives the ability to apply for additional state and federal funding opportunities.* The primary barriers to achieving RI Prevention Certification include: *the process takes too long, collecting required documents is difficult, not sure if the certification is worth the investment and test aversion.*

During the next provider needs assessment survey, questions around job satisfaction should be included. This needs assessment will be performed in 2016. This will aid in BHDDH's plan to assist in the following: prevention of field turnover, retention, job satisfaction, protocols for transitioning new coordinators into their positions, create job descriptions and salary levels based on certification. Providers will be asked to complete a self-assessment, developed by the RIPRC, to document areas of expertise, and areas in need of additional professional development. Self-assessment will be used as an individual's strategic plan. Self-assessment can promote individual responsibility and ownership of professional development, and it can be used to identify training and gaps.

We have developed an employment classification to aid in workforce development. They are:
THREE- TIERED PREVENTION EMPLOYMENT CLASSIFICATION

SPECIALIST I

Model Job Duties/Responsibilities

- Enter and analyze data

- Write management plans and other accountability reports
- Develop and implement all six CSAP strategies (if the agency offers all six)
- Work with and manage coalition members
- Plan
- Partner with law enforcement, education, treatment, recovery, etc.
- Coordinate activities
- Conduct needs assessment
- Work with evaluator
- Acquire resources
- Work with media
- Advocate for prevention

Qualifications/Other Details

- Appropriate entry-level classification for new prevention professionals with associate's degrees
- AA (Associate of Arts), AS (Associate of Science), ABA (Associate of Business Administration) and ABS (Associate of Business Science). Experience preferred. Degree in appropriate content area preferred.
- Should be seeking APS (Associate Prevention Specialist) status in accordance with BHDDH guidelines.
- Needs prevention trainings as outlined in the RI Certification APS or CPS Applications

PREVENTION SPECIALIST II

Model Job Duties/Responsibilities

- Enter and analyze data
- Write management plans and other accountability reports
- Develop and implement all six CSAP strategies (if the agency offers all six)
- Work with and manage coalition members
- Plan
- Partner with law enforcement, education, treatment, recovery, etc.
- Coordinate activities
- Conduct needs assessment
- Work with evaluator
- Mentors newer staff
- Acquire resources
- Oversees budgets
- Work with media
- Advocate for prevention

Qualifications/Other Details

- Appropriate classification for a Prevention Specialist I who has achieved APS status or when a new employees is hired with a bachelor's degree or considerable social service experience

- If hiring from the outside field, a bachelor's degree is preferred with content specialty and experience .
- Should be seeking CPS status in accordance with BHDDH guidelines if hired from outside the field, or seeking CPSS status if already a CPS
- Needs prevention trainings as outlined in the RI Certification CPS or CPSS Applications

PREVENTION SPECIALIST III

Model Job Duties/Responsibilities

- Supervise prevention staff
- Enter and analyze data and use as basis for continuous quality improvement
- Write and manage grants
- Guide strategic and service planning processes
- Write management plans and other accountability reports
- Mentor newer staff
- Provide training and technical assistance for the community and field in general
- Oversees budgets
- Lead coalitions and be a leader in collaborative efforts
- Maintain expertise in prevention content areas
- Use logic models effectively
- Partner with law enforcement, education, treatment, recovery, etc.
- Coordinate and integrate multiple activities
- Conduct needs assessment
- Oversee evaluation processes
- Acquire resources
- Work with media
- Advocate for prevention

Qualifications/Other Details

- Appropriate classification for Prevention Specialist II who has achieved CPSS status
- Master's degree preferred. Experience preferred. Degree in appropriate content area preferred.
- Should demonstrate proficiency in those tasks that overlap with Prevention Specialist II

In order to assist communities Task Forces in meeting the workforce development goals the Rhode Island Prevention Resource Center was established by the Department.

A core function of the RIPRC is to promote local, state, regional and national training and other learning opportunities that meets certification requirements and thus, the development of its workforce. Training sessions should be available in multiple modes, face-to-face, online courses, webinars, etc. Technical assistance may also be documented to meet the RI certification requirements. The RIPRC will offer group training and technical assistance for coaching/mentoring to move individuals from one level of Prevention Specialist to another. The identification of additional funding sources and/or scholarships is important to increase access to training and increase the number of providers who are Certified Prevention Specialists in Rhode Island.

CERTIFICATION:

The Rhode Island Certification Board (RICB) - The RIBC defines a baseline standard for all credentials offered. Counselors are given recognition for meeting specific predetermined criteria in substance abuse. The RIBC has been a participating member in the International Certification & Reciprocity Consortium (IC&RC) since 1988. (IC&RC sets international standards for counselor competency and develops and maintains written examinations for each reciprocal credential offered.) BHDDH worked with the RIBC in order to develop an entry level certification to meet the needs of our prevention coalition staff who work at a part- time basis. The Associate Prevention Specialist (APS) requires less educational and job experience hours. This has increased our workforce certification.

Certification is an important component of workforce development in the area of substance abuse prevention. Certification in the field of substance abuse prevention is based on knowledge in the 6 performance domains that are designed to help the workforce to prevent or reduce the conditions that place individuals at increased risk of substance abuse related issues. This would help to make sure the capacity of the workforce is level across communities. This would mean that regardless of where an individual working in the field is from, efforts are made across communities, and the State as a whole, to ensure that the workforce has the same level of competency to deliver prevention services. We have increased the number of certified Applied Prevention Specialists (APS), Certified Prevention Specialists (CPS), and Certified Prevention Specialist Supervisors (CPSS). Activities that will aid in the certification process include: development of a certification study guide, or specific training geared towards assisting individuals in obtaining certification. We have offered two specific trainings to prepare providers for certification and we will finalize a certification guide in the fall of 2015.

The 2015 Prevention Specialist Job Analysis identified six performance domains and associated tasks for the IC&RC Prevention Specialist Examination. These are described in the IC & RC Prevention Specialist Candidate Guide found at http://www.ricertboard.org/uploads/2/4/5/3/24535823/ps_candidate_guide_4-15.pdf

STRATEGIC PLANNING AND WORKFORCE DEVELOPMENT

Our State Action Plan for an Integrated System of Care includes the development of a qualified workforce to meet the unique treatment and prevention needs of individuals with co-occurring disorders. The plan was created to take advantage of opportunities to explore enhanced infrastructure to increase awareness and capacity among stakeholders within the system, while creating greater integration and efficiencies of the system as whole.

WORKFORCE DEVELOPMENT ACTION STEPS:

- I. **Increased availability of training that support improvement of certification rates among prevention providers, as well as maintaining up-to-date credentials.**

Certification of prevention providers helps to ensure that the workforce has a core set of competencies to effectively work within the prevention and mental health

promotion system. Making sure trainings are available that are tied to core certification domains will help to increase these core competencies. Also, trainings and technical assistance opportunities should include targeted curricula to address the specific needs of more advanced professionals, such as continuing education requirements of the Certified Prevention Specialist.

As of December 2013, 26% of RISAPA grantees are Certified Prevention Specialists or Certified Prevention Specialist Supervisors. The State's strategic plan would like to see this increase to 75% (Goal 4: Objective 1) by December 31st, 2015. Funded providers need to be accountable for increasing the numbers of certified individuals in order to reach this goal. Additionally, it will be important for the State to identify deadlines in moving towards this goal to monitor the increased credentialing of its workforce. If funded providers do not meet established deadlines, BHDDH will need to determine how to make providers accountable. Strategies such as corrective action plans or the withholding of grantee funding for non-compliant providers may be possible options.

Increase the utilization of RIPRC TTA services. TTA are critical components of workforce development. Available and accessible TTA are key in this area. The identification of strategies towards implementation of both in-person and online TTA will help to increase potential utilization across multiple training modalities. The 2014 training and technical assistance needs assessment reported 90% of providers participated in RIPRC training sessions and 79% accessed technical assistance services. The goal is to increase the number, from 79% to 90% of prevention providers who have accessed technical assistance services and increase from 90% to 100%, the number of funded prevention providers will have participated in a minimum of one (1) RIPRC sponsored training session by July 30, 2016.

- II. Behavioral healthcare providers across multiple disciplines utilize some skills that may be transferable, or complimentary to ones' own discipline. The identification of supplemental trainings for topics such as motivational interviewing, monitoring and evaluation, facilitation skills building, recruitment of qualified staff, etc. may be available within other or complimentary networks of workers. This in turn may assist in having individuals interact outside of programmatic silos. This may also lead to the sharing of salient resources.

Additionally, training and technical assistance opportunities should be made available to prevention providers regardless of their funding source to create greater equity among the workforce. For example, this may include student assistant counselors who are required to have a supervisor, but one is not available at their place of employment. By creating tailored opportunities to increase capacity and meet job specific requirements this will help to make sure core requirements are met. Such opportunities should be considered when planning training and technical assistance opportunities around workforce development.

- III. **Implement a training needs assessment every two years.** The identification of training and technical assistance that meets the needs of its workforce is critical. A

regular assessment of helps to ensure that the training is appropriate and targeted in meeting the needs of its workforce. The long-term sustainability of valid and properly trained workforce depends on it. The next training and technical assistance needs assessment will be implemented the fall 2016.

- IV. **Cultivate, acknowledge, and promote prevention specialists and content specialist to encourage leadership within the field.** The identification of leaders across multiple domains within the network of prevention providers is important to promote and effect change. A minimum of five (5) prevention leaders will be identified, by BHDDH, based on advanced skills and content expertise by December 2015.

The substance abuse prevention field in Rhode Island has evolved over time. In order to most appropriately and effectively adapt to change, so must its workforce. To increase the capacity and sustainability of the State's prevention and mental health promotion system it is important to thoughtfully and strategically plan for its future. Monitoring and evaluation of key programmatic and workforce initiatives are critical in determining the efficacy, sustainability, and cost effectiveness of the current system, as well as what potential changes need to be made. Providing and promoting training, technical assistance and capacity building that is adequate and accessible will help to prepare individuals and organizations to work within this system. And last, opportunities to cultivate leadership to effect and promote change are important to help navigate this evolving system.

The workforce development plan will help to support the following:

- An expanded workforce that understands the changing requirements and needs of its communities;
- Increased awareness and capacity of providers within the system;
- Providers who utilize data driven planning and decision making;
- Community resources that are mobilized appropriately and effectively;
- A system characterized by increased integration, coordination, leadership and communication; and,
- A system that is able to adapt to emerging trends while being sustainable and cost effective.

Meeting the challenges associated with maintaining a viable workforce is significant. As previously discussed, that includes the recruitment of new employees and the retention of current ones, as our workforce ages into retirement or changes careers. BHDDH is dedicated to the recruitment, retention, education, and training of its substance abuse prevention professionals and to improving the quality of our workforce. Creating and implementing a workplace development plan will support Rhode Island in its efforts to create an expanded, more sophisticated prevention workforce that is able to adapt and flourish within an evolving system. Rhode Island is working to increase the capacity of community coalitions to use a standardized readiness assessment tool. We began a pilot process with the Partnership for Success communities, who were required to use Colorado State University Tri-Ethnic Center for Prevention Research's Community Readiness for Community Change assessment tool and workbook as part of their strategic planning process. The communities were asked to describe

the levels of readiness across the five key dimensions of community knowledge of the issue, community knowledge of efforts, community climate, leadership and resources. Communities were asked to address any needed capacity building efforts to increase community readiness or resources.

BHDDH uses the Strategic Prevention Framework five-step process to assess our prevention needs based on epidemiological data, to build our state capacity, to develop a strategic plan, to implement effective community prevention programming, policy and practices and then to evaluate the outcomes.

The State Epidemiological Outcomes Workgroup performs substance abuse assessment, monitoring and surveillance using the Strategic Prevention Framework (SPF). The SEOW has institutionalized data-driven decision making for state and community level prevention planning and expanded the focus to integrate behavioral health indicators such as preventing mental illness and promoting positive mental health as it relates to substance abuse. The SEOW has also addressed the need to assess and learn how State Epidemiologic and Outcome Workgroups have influenced state and community prevention planning.

The purpose of the 2015 Rhode Island State Epidemiological Profile (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 by providing a user-friendly and 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 various populations (i.e., youth vs. adult).
- Mental and behavioral health outcomes across the State of Rhode Island.
- Potential risk and protective factors associated with substance use and mental illness.

The Profile contains most relevant data on statewide substance use and abuse (consumption patterns), alcohol consumption patterns, mental health, short- and long-term consequences, and risk and protective factors and is able to compare RI to national and regional (including New England and the Tri-state) averages.. New to this Profile are more in-depth background and RI demographic context. This Profile included more data of population, age groups, specific racial and ethnic groups, foreign born and language, education, income, labor force data including unemployment rates, homelessness status, and health insurance coverage.

In addition, this Profile provided data by age group and time-trend for many of the topics presented. Keeping the inherent limitations in mind, the data summarized in the Profile can be utilized for promotion, prevention, treatment, recover and health-care planning for the State of Rhode Island.

National, regional, and state data sources identify alcohol abuse and underage drinking as continuing state priorities. These continue to be problem areas but have shown downward trends nationally and within our state. **Table 1** below provides a summary of Rhode Island verses United State comparisons for underage drinking among the underage population from 2001 to 2013 from the Youth Risk Behavior Surveillance System. Levels of youth drinking before age 13 and

problem use (binge drinking) are consistent with other northeastern states and typically lower than the US overall.

% of Students (grades 9-12) Reporting:	2001			2009			2011			2013		
	RI	US	Ratio RI/US									
Alcohol Use												
Alcohol use past month	50.3	47.0	1.07	34.0	41.8	0.81	30.0	38.7	0.78	30.9	34.9	0.89
Binge drinking past month	30.7	29.9	1.03	18.7	24.2	0.77	18.3	21.9	0.84	15.3	20.8	0.74
Initial use of alcohol before age 13	29.7	29.1	1.02	15.8	21.1	0.75	15.6	20.5	0.76	13.5	18.6	0.73

Table 1 - RI vs. US Comparison on Ten Key Consumption Indicators for Underage Population (<18), 2001-2013 *Source: Youth Risk Behavior Survey, Centers for Disease Control*

Drinking and driving past month	15.5	13.3	1.17	7.2	9.7	0.74	6.5	8.2	0.79	8.5	10.0	0.85
In car w/ driver who had been drinking (past month)	32.3	30.7	1.05	23.1	28.3	0.82	21.9	24.1	0.91	20.1	21.9	0.92
Cigarette Use												
Smoking cigarettes 20+ days past month	14.2	13.8	1.03	5.4	7.3	0.74	4.4	6.4	0.69	3.1	5.6	0.55
Initial use of tobacco before age 13	22.3	22.1	1.01	8.4	10.7	0.79	7.1	10.3	0.69	5.6	9.3	0.60
Marijuana Use												
Using marijuana past month	33.2	23.9	1.39	26.3	20.8	1.26	26.3	21.3	1.23	23.9	23.4	1.02
Initial use of marijuana before age 13	12.8	10.2	1.25	8.3	7.5	1.11	7.1	8.1	0.88	6.8	8.6	0.79
Prescription Drug Use												
Prescription drug misuse past year	--	--	--	--	--	--	14.1	20.7	0.68	13.5	17.8	0.76

Note: Ratios greater than 1 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 1 indicate those consumption patterns where RI is lower than the US average

Table 2 – RI vs. Region Comparison on Marijuana Consumption for Underage Population (<18), 2001-2013

	USA	RI	CT	MA	ME	NH	NJ	NY	PA	VT
	% Using marijuana past month									
2001	23.9	33.2	--	30.9	27.2	--	24.9	--	--	30.3
2009	20.8	26.3	21.8	27.1	20.5	25.6	20.3	20.9	19.3	24.6
2011	23.1	26.3	24.1	27.9	21.2	28.4	21.1	20.5	--	24.4
2013	23.4	23.9	26	24.8	21.3	24.4	21	21.4	--	25.7
	% Initial use of marijuana before age 13									
2001	10.2	12.8	--	11.9	12	--	9.2	--	--	12.2
2009	7.5	8.3	5.8	9	9.8	8.4	4.1	7.7	5.3	8.7
2011	8.1	7.1	6.3	6.9	7.3	7.7	4.3	7.6	--	6.4
2013	8.6	6.8	7	6.6	7.1	6.6	5.1	7.3	--	8.4

Note: RI Indicators greater than national averages are shown in red.

RI indicators less than national averages are shown in green.

Source: Youth Risk Behavior Survey, Centers for Disease Control

Rhode Island continues to identify underage marijuana use as a priority. The YRBS data shows that the under eighteen population for using marijuana in the past month is higher by 1.02 in the consumption pattern ratio where Rhode Island exceeds the United States average. We predict this will continue to increase based on the changing political landscape around medical marijuana and its perceived risk. The *State Estimates of Substance Use from the 2011-2013 National Surveys on Drug Use and Health* (Office of Applied Studies, NSDUH Series H-37, HHS Publication No. SMA 10-4472, Rockville, MD) reports that time-trend rates of perceptions of great risk of smoking marijuana once per month have declined. Rhode Island's rates are lower than the national. We anticipate this will result in rates of use increasing in the future. In no other state did as many people report having used marijuana in the past month: 14 percent of those age 12 and older, up from 13 percent the previous year, according to the National Survey on Drug Use and Health. Rhode Island was also tops for those who reported having used marijuana in the previous year: 20 percent, up from 19 percent. In **Table 2** above the Youth Risk Behavior Survey shows that Rhode Island in comparison to the region rates for marijuana consumption for the underage population higher than the United States, Maine, New Jersey, and New York. The regional comparison for initial use of marijuana before age 13 shows Rhode Island higher than Maine, New Hampshire and New Jersey. An examination of program and policies regarding possession and access to marijuana for this particular population may be useful to determine which components may be affecting the use of marijuana.

While we have reason to believe that Rhode Island's ability to impact underage drinking may have resulted from the SPF-SIG effort in RI (Florin, et al., 2012) there are compelling reasons to continue to focus efforts in Rhode Island on a priority of underage drinking. One of these of course is the simple fact that prevention is never done once and for all, that new cohorts of youth continue to be exposed to personal and community risk factors for early use and, potentially, problem use of alcohol. Another, more specific reason for underage drinking as a prevention priority is that the targeted high need communities in this SPF PFS initiative experienced only a modest decline in underage drinking that was one-third the impressive reductions experienced in the remainder of the state. Finally, only three of the eight identified alcohol high need communities (Newport, Providence and Westerly) were involved in the prior SPF-SIG. We expanded our underage drinking efforts under the SPF-SIG to additional, new communities, while still shoring up some of the previous SPF-SIG communities that warrant attention.

BHDDH applied for and received the Strategic Prevention Framework Partnerships for Success 5-year grant. In Rhode Island we identified twelve high need communities to address underage drinking and marijuana use among youth under the SPF PFS grant. In addition, Rhode Island intends to use the SPF PFS grant program as an opportunity to assess prescription drug use and misuse among youth ages 12 - 25, and resulting burden. Currently, there are only very limited data available specific to Rhode Island on prescription drug use and misuse among youth ages 12-25. Data from the Youth Risk Behavior Survey data indicate that 11% of Rhode Island public high school youth abuse prescription medications in their lifetime. In 2011 we began collecting prescription drug misuse in the past year on our Youth Risk Behavior Survey. In **Table 3** our region comparisons rates on underage prescription drug consumption were higher than Maine and New Jersey. We will use the SPF PFS as an opportunity to compile all available data and conduct new state and sub-state analyses to assess our needs and get a better understanding of the incidence and prevalence of prescription drug use and misuse in order to consider potential prevention strategies.

Table 3
RI vs. Region Comparison on Prescription Drug Consumption for Underage Population (<18), 2011-2013

	USA	RI	CT	MA	ME	NH	NJ	NY	PA	VT
	% Ever took prescription drugs without a doctor's prescription									
2011	20.7	14.1	--	--	13.9	20.8	15.1	--	--	--
2013	17.8	13.5	--	--	12.4	16.5	11.8	--	--	--

Note: RI Indicators greater than national averages are shown in red. RI indicators less than national averages are shown in green. Source: Youth Risk Behavior Surveillance System (YRBSS)

SPF PFS Overview:

Twelve (12) Rhode Island communities have received funds for substance abuse prevention activities targeting underage drinking and youth marijuana use. These communities were identified as high need based on their youth prevalence rates and a set of social indicators related to negative consequences of substance abuse based on the 2013 State and Community Epidemiology profiles. (See Table 4 below). Funding for the communities began July 1, 2014 and ends September 29, 2018.

Underage Drinking	Marijuana Use by Youth 12-17	Both
Burrillville	Cumberland	Foster
Cranston	Lincoln	Johnston
Providence	Little Compton	Newport
Westerly	Scituate	New Shoreham

Major Benchmarks Achieved From July 1, 2014 to August 30, 2015

- Contracts were issued in July 2014 and eleven (11) of the (12) funded communities have submitted a final community level strategic plan or a final draft plan.
- Implementation will start in the summer of 2015.
- Five face to face trainings and six webinars or e-learning opportunities were offered to sub-recipients in between July 1, 2014 and June 30, 2015.
- State level advisory and workgroups formed and receiving staff support
 - State Epidemiology and Outcomes Workgroup
 - Prevention Advisory Committee of the Governor’s Council on Behavioral Health
 - Evidence Based Practices Workgroup

BHDDH and its key stakeholders have developed the following strategic prevention plan. The **purpose of this plan** is to outline high priority goals and strategies to strengthen the infrastructure and to provide support at the State and community-level in service to the prevention and reduction of alcohol and drug abuse in Rhode Island (RI). The plan reflects on-going efforts to use data and key stakeholder and community participation to set goals and objectives; prioritize evidence-based programs, practices, and policies; coordinate activities; determine key data indicators and evaluation plans to measure outcomes; identify target populations to reduce disparities related to substance use; and plan for the sustainability of infrastructures and activities. Ultimately, this plan should help to increase the overall readiness and capacity to carry out the activities associated with this plan. This document is meant to assist key stakeholders, prevention workforce members, and policy makers in providing a roadmap towards achieving the plan's goals.

BHDDH utilizes the Strategic Prevention Framework (SPF) developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). The framework uses a five-step process known to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the life course. The SPF is built on 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 idea behind SPF is to use the findings from public health research along with evidence-based prevention programs to build capacity across various geographies and populations, as well as the prevention field. This in turn will promote resilience and decrease risk factors in individuals, families, and communities.

The Strategic Prevention Framework Steps requires 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
- Evaluate efforts for outcomes.

Throughout all five steps, it is important to recognize that implementers of the SPF must address issues of sustainability and cultural competence.

The goals and objectives of Rhode Island's strategic planning efforts focus around 3 key areas: 1) system-level awareness and capacity; 2) system-level capacity and sustainability; and, 3) local capacity building. The goals and objectives associated with the State's plan become an important component in developing the knowledge, skills, and capacity of those working in the field. Each of these areas is important to developing a workforce that is better able to handle the evolving needs of the prevention provider landscape and mobilize the most appropriate community resources in response to these needs.

1) Key Area 1: Critical to the State's workforce development efforts include increasing **system-level awareness and capacity** through:

- Surveillance, evaluation and reporting (Goal 1: Objective 1);
- Communication (Goal 1: Objective 2);
- Training and Technical Assistance (Goal 1: Objective 3); and,
- Leadership development (Goal2: Objectives 1-3).

Goal One: *Improve the awareness and capacity to integrate prevention and mental health promotion across behavioral health provider systems and sectors.*

Objective I: By August 2014 (and each year thereafter), BHDDH will document the surveillance of current providers for prevention and mental health promotion on the state and community level(s) to ensure contractual 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 Rhode Island Prevention Advisory Committee PAC and to the Governor's Council on Behavioral Health. The summary report will document the integration of mental health promotion and alcohol, tobacco and other drug (ATOD) initiatives across the following state and community level organizations:

- a) State-level:
 1. URI, Statewide Evaluation Contract
 2. State Epidemiology Outcomes Workgroup (SEOW)
 3. RI Prevention Resource Center (RIPRC)
- b) RI Substance Abuse Prevention Act (RISAPA) Grantees
- c) Marijuana and Other Drug Initiative (MOD) Grantees

Objective II: By December 31st, 2015 maintain a consistent and regular schedule of behavioral health group meetings. Each meeting will specifically identify opportunities to address the following: 1) to increase communication across the sectors; 2) to identify increased opportunities for collaboration; and 3) to ensure promotion of existing services and initiatives.

Meetings will include and meet as follows:

- a) Governor's Council on Behavioral Health: Monthly
- b) SEOW: Quarterly
- c) IC & RC Prevention Certification Boards: Quarterly
- d) PAC: Quarterly
- e) RISAPA: Grantees: Monthly
- f) RIPRC: Biweekly
- g) MOD Quarterly

Objective III: By December 31st, 2015 BHDDH (directly or through a contract) will provide a minimum of 4 to 6 on-line or face-to-face trainings and a minimum of 20 to 30 technical assistance opportunities annually.

The purpose of the TTA opportunities is to increase the capacity of providers to integrate 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: By December 31st, 2015 increase the number of RISAPA grantees who are actively (not expired) Certified Prevention Specialists (CPS) or Certified Prevention Specialist Supervisors (CPSS) from 26% (as of 12/05/13) to 75%.

Having a greater number of CPS will help to meet workforce development goals to increase the capacity, knowledge, skills and organizational development of prevention and mental health promotion providers to address complex ATOD problems and consequences, as well as, self-harming and adverse behavioral health consequences.

Critical to the State's workforce development efforts also include **building local capacity** through:

Increasing the number of certified CPS and CPPS (Goal 4: Objective 1); and,
Utilizing data-driven program planning (Goal 4: Objective 2, 3)

Goal Two: *Convene a Rhode Island Prevention Advisory Committee (PAC) as a committee of the RI Governor's Council on Behavioral Health, to provide guidance to support the administration of substance abuse prevention and mental health promotion services across the state.*

Objective I: By December 31st, 2015 recruit a minimum of 15 professionals representing a broad range of content expertise (*refer to list below*) to the PAC.

The purpose of the PAC is to coordinate the State's strategic efforts to reduce the incidence and prevalence of ATOD misuse and abuse, as well as provide leadership and continuity to advance ATOD prevention and mental health promotion (MHP).

- 1) BHDDH Prevention and Planning Unit*
- 2) Department of Health (HEALTH) and/or Community Violence Prevention and/or Suicide Prevention *
- 3) RI Substance Abuse Prevention Act (RISAPA) *
- 4) Mental Healthcare
- 6) Certified Prevention Specialist*
- 7) Student Assistance Program *
- 8) State Epi Outcomes Workgroup (SEOW) *
- 9) Department of Youth and Family Services Prevention Specialist/Family Community Care Partnership Representative (s)

- 10) Military Prevention
- 11) School-based Healthcare
- 12) Community/School Health Educator (s)
- 13) Physical Healthcare Provider (s)
- 14) Parent Organization
- 15) Law Enforcement
- 16) Tobacco Control Prevention Specialist (s)
- 17) Recovery and Treatment
- 18) Developmental Disabilities
- 19) RI Department of Education
- 20) Youth Organizations
- 21) Mental Health Promotion

Please note: sectors followed by an asterisks (*) are required representatives.

Objective II: By March 31st, 2014, the RI Prevention Advisory Committee will meet on a quarterly basis specifically to 1) review current prevention research; 2) review ATOD Prevention/MHP policy updates; 3) develop new ATODP/MHP policies (as needed); and, 4) disseminate quarterly meeting notes and action items.

This will be accomplished by developing and reviewing strategic planning to ensure inclusion of prevention initiatives in the Governor's Council on Behavioral Health recommendations, serve as an expert panel for state and community programming and report on prevention initiatives to the Governor's Council on Behavioral Health.

Objective III: By December 31st, 2015, the RI Prevention Advisory Committee will assist BHDDH and the Governor's Council on Behavioral Health to document the deliverables outlined in the RI Strategic Plan for Substance Abuse Prevention in a written annual report.

The purpose of the report is to document sustainability outcomes, reinforce collaborative efforts, reduce redundancies, and align the state's resources to achieve specific collective objectives outlined in the current RI Strategic Plan for Substance Abuse Prevention.

- 2) Key Area 2: In order to increase **capacity and sustainability** of the State's prevention and mental health promotion system monitoring and evaluation are critical in determining the effectiveness, sustainability, and cost effectiveness. In particular, process and outcome monitoring becomes key in understanding whether the workforce is being properly developed and the system has a viable, professional workforce. The current plan accomplishes this by:
 - Annual reporting of process and outcome measures with recommendations for improvement (Goal 3: Objective 1);
 - Developing a plan for long-term system sustainability (Goal 3: Objective 2); and,

- Understanding the feasibility and cost-effectiveness of regionalization of prevention provider networks (Goal 3: Objective 2).

Goal Three: *Evaluate and sustain RI prevention and mental health promotion system.*

Objective I: By December 31st, 2014 (and for each 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 31st, 2015 BHDDH will develop a sustainability plan (to begin implementation in January of 2016) to specifically outline prevention and mental health promotion programming, policies and initiatives.

Objective III: By July 1, 2014, BHDDH will assess, in collaboration with community providers, the feasibility of implementing regional prevention provider networks to examine its potential cost-effectiveness and sustainability as a population- based prevention system strategy.

Goal Four: *Based on the current epidemiology and community profiles provided by the State Epidemiology Outcomes Workgroup (SEOW), community-based needs assessment data, and State youth and adult behavioral health data, improve outcome focused processes across prevention and mental health promotion providers.*

Objective I: By December 31st, 2014 (and for each year after) BHDDH will ensure the RI Prevention Resource Center, RI substance abuse providers, and Drug-Free Community Grantees and other prevention providers collect data, report data, and identify data-driven program planning in their reporting according to the following:

RISAPA Grantees – Monthly Reporting
 Drug-Free Community Grantees – Quarterly Reporting
 MOD Grantees – Quarterly Reporting
 RIPRC – Quarterly Reporting and Annual Report

Objective Ia: By December 31st, 2015 state/regional/locally funded prevention providers will select a minimum of 2 of SAMHSA's Prevention and Substance Abuse and Mental Illness goals (presented below) in the development of program planning and will utilize State and local data to inform these data-driven programmatic planning activities in their reporting.

We met the above goals in our Strategic Plan. In 2015 we began the process of updating this Plan. We held internal and external meetings with stakeholders to brainstorm around the new landscape in Rhode Island and to develop new goals and objectives. They will include financial sustainability; specificity around opioid misuse and abuse;

We will include also include the new SAMHA's 2015-2018 Prevention of substance abuse and mental illness goals:

Goal 1.1: Promote emotional health and wellness, prevent or delay the onset of and complications from substance abuse and mental illness, and identify and respond to emerging behavioral health issues

Goal 1.2: Prevent and reduce underage drinking and young adult problem drinking.

Goal 1.3: Prevent and reduce attempted suicides and deaths by suicide among populations at high risk.

Goal 1.4: Prevent and reduce prescription drug and illicit opioid misuse and abuse.

Evidence Based Practices Workgroup of the Prevention Advisory Committee/RI Governor's Council on Behavioral Healthcare

This workgroup is being convened under the auspices of the Prevention Advisory Committee of the Governor's Council on Behavioral Health to: (1) develop guidelines for ascertaining whether a given practice, policy or program meets existing standards for evidence based practice in behavioral health; and (2) identify a process by which an innovative or locally developed behavioral health practice, policy or program can be designated as an evidence based practice in Rhode Island.

An Evidence Based Practices Workgroup is required under SAMHSA's Partnership for Success (PFS) Initiative and the initial focus of the group is to perform the two tasks described above as it relates to the PFS. Once guidance and operating procedures are approved by the workgroup membership and refined for use across the behavioral health continuum, they will be submitted to the Governor's Council for their consideration and potential adoption for use across state agencies that provide behavioral healthcare services. The membership of the group is drawn from various behavioral health disciplines and includes but is not limited to service providers, researchers, epidemiologists and consumer advocates. The group has met six times since it's inception in October 2014.

FFY 2015 Major accomplishments during the past federal fiscal year have included identifying various federal registries that may be sources of evidence based practices, policies and programs; suggesting resources that can be used to help locate peer reviewed journal articles that can be additional source of evidence practices for emerging substances or populations; providing guidance on how to identify sound sources of peer reviewed literature; identifying a set of review criteria to apply to innovative or locally developed programs or practices that would seek designation as evidence based in Rhode Island; and defining three tiers for the practice or intervention along a continuum of evidence.

FFY 2016 Next steps for the EBP-W is to finalize the three tiers of evidence based practices, create a process by which an innovative or locally developed behavioral health practice can be

designated as evidence based and develop operating procedures for a panel experts who would review any application for a practice or intervention that would seek designation as a behavioral health evidence based practice.

BHDDH Prevention System:

- In 1987 the Rhode Island General Assembly passed the Rhode Island Prevention Act (RISAPA) RI General Laws 16-21). RISAPA promotes comprehensive prevention programming at the community level. 35 municipal task forces, covering all of the state's 39 cities and towns engage in local needs assessments; and planning, implementation, and evaluation of strategies, policies, and programs to produce long term reductions in substance use and abuse by using at least three out of the six CSAP Strategies to include information dissemination, alternative activities, community based process, and environmental strategies.
- In July 1992, Congress enacted the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act (PL 102-321), which includes an amendment (section 1926) aimed at decreasing youth access to tobacco. This amendment, named for its sponsor, Congressman Mike Synar of Oklahoma, requires states (that is, all states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and six Pacific jurisdictions) to enact and enforce laws prohibiting the sale or distribution of tobacco products to individuals under the age of 18. States must comply with the Synar Amendment in order to receive their full Substance Abuse Prevention and Treatment Block Grant (SABG) awards. The Synar Amendment was developed in the context of a growing body of evidence about the health problems related to tobacco use by youth, as well as evidence about the ease with which youth could purchase tobacco products through retail sources. The Synar program has been successful in preventing youth tobacco use. Within Rhode Island the Synar program requires states to have in place a law prohibiting the sale or distribution of tobacco products to children under the age of 18. The program annually surveys random retail tobacco outlets statewide to determine retailer compliance with the youth access law which is a successful environmental strategy.
- 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 seeks to attain two overarching goals: one, identify individuals ages 12-18 who are exposed to risks or experiencing early symptoms that increase the potential that they will use or misuse alcohol and/or other substances as

described in *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities* (Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors; Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions; Institute of Medicine; National Research Council; 2009), *Prevention of Substance Abuse and Mental Illness in Leading Change: A Plan for SAMHSA's Roles and Actions 2011 - 2014*, (Substance Abuse and Mental Health Services Administration, 2011), two, take action prior to there being a diagnosable substance use disorder. Successful screening and preventative interventions can reduce diagnosable disorders that require treatment.

Rhode Island Student Assistance is a school based alcohol, tobacco and other drug abuse prevention/early intervention program. The SAMHSA/CSAP model problem identification and referral program Project Success (formerly Westchester Student Assistance Program) is used. It is available in 42 schools, representing 18 districts. 3,775 students have been served by on-site Master's level counselors from August 2014 to July 2015. In order to have clearer fidelity and outcome measures BHDDH performed a Request for Proposal process and identified one provider to perform the student assistance work in a more cost effective manner which includes expansion into 45 schools and more than doubling the number of student served. Information Dissemination will include written communications to students, schools, community coalitions, parents and outside service providers.

- In 2010 we reallocated SAPT Block Grant dollars to fund the Reducing the Use of Marijuana and Other Drugs (MOD) for five years. We currently fund nine providers to implement and manage substance abuse prevention programming in nine local high schools that include implementation of evidence-based programs and strategies to prevent substance use and abuse and implementation of preventive interventions with youth a high or highest risk for abuse of marijuana and other illicit drugs. The Reducing Use of Marijuana and Other Drugs initiative seeks to attain the following goals: a measurable reduction in the percent of in-school, high school-aged (grades 9 – 12) youth reporting current (past 30-day) use of marijuana and other drugs; and a measurable increase in the percent of in-school, high school-aged youth expressing disapproval of use of marijuana and other drugs. The Initiative includes recruitment with the high school and administration of a student school survey. The SSA funds the provider to provide Universal Direct to an entire grade of students, Universal Indirect to entire school population, including students and staff and Selected Indicated, Community Based, Alternatives, Problem ID/Referral, Environmental, and Information Strategies in their schools as well as their communities.

This Initiative has contacts with approximately 7,000 students per year that are exposed to social marketing/social norms campaigns. The University of Rhode Island (URI) performs process & outcome evaluations and examines that the fidelity measure are being met for evidence based programming. It collaborates with SEOW on transfer of outcomes and technology from science and research to practice at the local level. The total target population for the initiative is 6,600 students. During the past three years, 4,770 students

have received direct intervention with evidence-based universal curriculums and 1376 students have received a Student Assistance Counselor Intervention.

Rhode Island developed a risk and prevalence student survey under the MOD that was administered twice during this Initiative. In comparing the two sets of data early results show a decline in 30-day use, an increase in perceived peer disapproval and an increase in perceived risk across multiple substances. The University of Rhode Island will provide the final evaluation results at the end of year five. Planning has begun to sustain the current communities at a lower level of funding and expand it to additional communities in FY17.

BHDDH requires that an annual application is submitted by each of the Rhode Island prevention coalitions. Included in this application is both a service and an implementation plan which incorporates community needs and resource assessment findings. All contract services are performed in conformance with the approved program service plan and are entered into a PBPS prevention data collection system. In their programmatic budget narratives coalitions are required to list additional funding sources other than SABG. BHDDH performs contract monitoring to ensure that SABG dollars that are used to fund primary prevention services are not funded through other means.

BHDDH is implementing a revised version of our prevention data collection system. This system will collect service, administrative, and fiscal information. The reports that will be provided reports are consistent with the data requirements of the SAPT Block Grant. Implementation of system will allow us to identify prevention strategies in specific areas of the Strategic Prevention Framework Partnerships for Success, RI Substance Abuse Prevention Act, Reducing Marijuana and Other Drugs and Student Assistance.

BHDDH has a long-term commitment to the evaluation of the implementation and outcomes of substance abuse prevention, mental health promotion, and prevention of mental illness programs and strategies funded by the Department. These evaluations assist BHDDH in the identification of programs and strategies (evidence-based practices) that are effective approaches to preventing alcohol, tobacco, and other drug use. Also, they assist BHDDH in identifying prevention programs and strategies that are effective with different populations. Evaluation outcomes, combined with epidemiological data, contribute to the maintenance of a data-driven planning process and to the development of performance measures necessary to determining best use of public resources. The Department's approach is also consistent with not only best practice but also with the Substance Abuse and Mental Health Services Administration's Strategic Initiative #1, Prevention of Substance Abuse and Mental Illness.

BHDDH has required expert consultation and technical assistance in order to determine the efficacy of preventive interventions, including consultation and technical assistance to providers. We currently work with the University of Rhode Island to perform expert evaluation of and reporting on substance abuse and mental illness prevention programs, strategies, and practices; consultation and technical assistance to the Department in the selection of evidence-based

practices; consultation and technical assistance to the Department on prevention planning; and recommendations to the Department on taking programs and strategies from science to practice.

The University of Rhode Island's Cancer Prevention Research Center (CPRC) will work with the following providers (Reducing Marijuana and Other Drug Initiative, Partnership for Success and Student Assistance) to assist in the administration of the RI Student Survey (RISS).

The RI Student Survey will be used to track 30-day prevalence of alcohol, marijuana and prescription drug misuse and abuse among 12-17 year olds at the community level. The RI Student Survey is a 54-item population survey (i.e., it includes all students in school on the day of administration) that will be administered bi-annually. The RI Student Survey contains items providing 30-day prevalence rates comparable to those provided at the state level by NSDUH and YRBS. In addition, the RI Student Survey asks about 30-day use of specific categories of prescription drugs (e.g., opioids / pain relievers; tranquilizers/sedatives and stimulants), allowing for a more refined assessment of trends in the non-medical use of particular types of prescription drugs. This substance abuse risk and prevalence survey will be administered to approximately 40,000 students in grades 6 through 12 in March-April 2016.

Rhode Island				CSAP SAPT
Primary Prevention for Substance Abuse Strategies				
FY16-17				
CSAP Strategies	Rhode Island Substance Abuse Prevention Act (RISAPA)	Rhode Island Student Assistance Program (SAP)	Reducing the Use of Marijuana and Other Drugs (MOD)	Synar
Information Dissemination	x	x	x	x
Prevention Education		x	x	x
Alternative Activities		x	x	
Community Based Process	x	x	x	x
Environmental Strategies	x		x	x
Problem Identification/ Referral	x	x	x	

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

BHDDH would like to request technical assistance in the development to a Continuous Quality Improvement Plan.

Footnotes:

Quality Improvement Plan

Quality Improvement Plan----that identifies and tracks critical outcomes and performance measures, effectiveness of services, track programmatic improvements w/stakeholder input, and process for responding to emergencies, critical incidents, complaints and grievances

DCYF has a comprehensive data and evaluation framework inclusive of a quality assurance system. The integrated statewide infrastructure that supports this includes the RIFIS management system for the FCCP, the DCYF RICHIST management information system, Administrative case reviews, Data Analysis and Program Evaluation which consist of DCYF staff and contracted services through Yale University's Consultation Center, monthly CQI meeting and a CQI feedback loop through numerous meeting and committees including the Family Community Advisory Boards. The DAC (Data Analytic Center) is a collaborative endeavor of DCYF with Yale University School of Medicine and System of Care Network Lead partners, local family Support Agency, Neighborhood Health Plan (local Medicaid managed care agency) to provide evaluation, research consultation and data analytic capacity for the DCYF divisions of child welfare, behavioral health and juvenile corrections.

BHDDH has protocol for monitoring quality, however, does not have a Continuous Quality Improvement Plan. Below is a description of the process that in place and lead by the Research, Data Evaluation and Compliance unit (RDEC):

- 1.) BHDDH's RIDE unit uses its Behavioral Health On-Line Database to track client utilization of services and outcomes using SAMHSA's National Outcome Measures. It also maintains a human resources database to track workforce trends at our providers. Finally, RDEC staff track client's with SPMI's satisfaction with person-centered treatment, access and other pertinent issues through BHDDH's Outcome Evaluation Instrument. We are looking to expand the use of this instrument to all clients served by the State-licensed behavioral Healthcare organizations (BHOs).
- 2.) Behavioral healthcare program staff respond to incidents and complaints about how clients are being treated by providers or each other. RDEC and the State's Department of Information Technology maintain a database that stores all of this data. Periodically RDEC staff run reports on trends and providers to inform program and policy staff within BHDDH.
- 3.) Behavioral healthcare program staff conduct biannual clinical audits of all of BHDDH's licensed BHOs. RDEC staff review BHO's data quality at these meetings and BHDDH licensing staff ensure that BHO's are compliant with licensing standards at these audits. BHOs that do not meet compliance standards in any of these program areas are required to submit a plan of correction.

BHDDH would like to request technical assistance in the development to a Continuous Quality Improvement Plan.

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma⁷⁵ is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems⁷⁶. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”.⁷⁷ This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁷⁸ paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

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

75 Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

76 <http://www.samhsa.gov/trauma-violence/types>

77 <http://store.samhsa.gov/product/SMA14-4884>

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Trauma

1. *Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?*

BHDDH - Yes, section 24.4.5, 24.4.17 and 29.3.6 of the States Rules and Regulations for Behavioral Health Organizations requires clinicians and substance abuse professionals to inquire about client's trauma history during assessment. Regulations around Behavioral Health Acute Stabilization Units (BHASU) require a trauma-informed search of clients prior to admission. According to section 43.4, all medical, nursing, and counseling staff working in outpatient detoxification units shall have training in, and have the ability to recognize, medical conditions associated with trauma, illness, and detoxification. Contracts for women's services require that services be provided in a trauma informed manner. All of BHDDH's Health Homes contracts with CMHO's require them to provide master's level counseling that addresses trauma.

DCYF has incorporated trauma informed care into existing policies and procedures including the development of standards of practice, based on wraparound philosophy with an emphasis on trauma. Based on the higher level of exposure to trauma of children and youth in the child welfare and juvenile justice system, all children and youth in care are screened for trauma using Child Adolescence Needs Strengths Trauma Module. The child/youth is assessed at the time of entry into care, every three months and at discharge from care. Information based on the results of the CANS identifies strengths, risk, and need for intervention which is incorporated into the child/youth's service plan and is assessed for progress.

2. *Describe the state's policies that promote the provision of trauma-informed care.*

BHDDH - A history of abuse, violence, trauma and sexual exploitation often contributes to the behavior of substance abusing and dependent women. Women's services contracts include the following standard for all women's services: Agencies/programs must develop a process to identify and address past and current abuse/violence/trauma/exploitation issues. Services will be delivered in a trauma-informed, trauma-sensitive setting and provide safety from abuse and exploitation, stalking by partners, family, other participants, visitors, and staff. Women's services must

1. Conduct an assessment that is sensitive to sexual abuse issues and sexual exploitation;
2. Demonstrate training and competence to address these issues;
3. Make appropriate referrals and ensure coordination of services;
4. Acknowledge and incorporate these issues into the treatment and discharge plans;
5. Assure that the client will not be exposed to exploitive situations that continue abuse patterns within the treatment process. BHDDH provides monitoring of adherence to this standard. Additionally the state has a designated Women's Services Network Coordinator, (WSN) which collaborates with other state and local community agencies who also serve trauma exposed consumers.

DCYF - See above

3. *How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?*

BHDDH - Regulations mandate the use of evidence based practices. The State regularly surveys providers to determine which evidence based practices and interventions are being used. Our state's most commonly utilized ones at present are Seeking Safety, TAMAR, and Dialectical Behavior Therapy, (DBT)

DCYF's goal is to develop an array of services that are evidence based and trauma informed practices that address the age, needs, and placement of the child or youth and the strengths and challenges of their families. Providers in the system of care for children, youth and families need to have sufficient training on the effects of trauma, completing trauma assessments, and knowledgeable of the appropriate treatments and services available. DCYF has been working with other state agencies and community providers to expand the availability of evidence based services which are trauma informed for a variety of specific populations such as early childhood and children and families not open to DCYF, children in placement and transiting home, children who are in the process of being adopted or have had a disruption in the adoption process to youth in the RI Training School and involved in the court system.

Through the assistance of ACF Child Welfare-Early Care and Education Partnership, a trauma informed-positive behavior support curriculum and training program was developed for early care education and other cross system partners. This training has been piloted and has a very positive outcome evaluation. The Truven report noted that children in Rhode Island were less likely to be enrolled in nursery school or preschool compared to other New England states. This imitative focuses on increasing the rate of enrollment of children in foster care in high quality early learning environments.

DCYF's Community providers have been incorporating trauma based treatment as part of their array of services through various funding sources. TF-CBT (Trauma focused Cognitive Behavioral Therapy) and TST, (Trauma Systems Therapy) are available through special congregate programs and for children/youth transitioning home. These services and others including EMDR (Eye Movement Desensitization and Reprocessing) are available through some local community mental health organizations by various funding mechanism.

DCYF's Title IV-B Child and Family Service Plan (2015-2019) has several specific activities to support children at risk for SED and those already diagnosed with a SED. One strategy is to expand and increase the array of community-based services to support reunification, to prevent re-entries into care, and to include activities for all congregate care staff that address the effect of providing trauma-focused care.

4. *Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?*

BHDDH - Our training contract ensures that training on trauma specific interventions are available to our provider network at least annually. BHDDH's Collaboration with the RI Coalition against Domestic Violence has resulted in the availability and our promotion of training on many domestic violence and trauma related issues. Training is also provided on sex

trafficking through our training contract and our participation with the New England Institute of Addiction Studies. Training on trauma related issues is also provided to the State's increasing numbers of recovery support services providers who often work with those needing integration and inclusion into their communities following incarceration and/or treatment.

DCYF has worked collaboratively with community resources to provide trainings about trauma and trauma specific interventions for various populations and providers. In a partnership with the RI Department of Health and the Department of Education, a trauma informed training was developed for child care staff and early learning professions throughout the state. This training through The Center for Early Learning Professionals trains child care staff in the skills necessary to ensure that children, birth to five who have experienced trauma, will be able to maintain placement in a quality center and work toward healing and a successful future. Research shows that intervening with evidenced base prevention supports as early as possible in a child's life gives children and families a strong foundation for future social-emotional development and well-being.

DCYF grant's initiative Adopt Well-Being addressed the need for resource families to meet the highest standards and to be trauma informed. This initiative ensures that the diligent recruitment of foster parents include training on trauma so that resource families will be trauma informed.

The Child Welfare Institute (CWI) provides training for DCYF staff in Trauma Informed Child Welfare Practice in collaboration with a community agency. Chapwick Center and a community provider conducted a three day Train the Trainer on Trauma Informed Child Welfare Practice in December 2014. In addition, many of the community providers for children, youth and families have provided a variety of trainings to the system of care community on various aspects of trauma.

The Chief Judge Haiganush R. Bedrosian of the Rhode Family Court sponsored a two day conference on October 28 and 29, 2014 on *Children, Trauma and the Integration of Care*. This conference covered various aspects, services, and systems and was attended by representatives from the medical, legal, court, child welfare, clinical, research, schools, juvenile justice professions. This conference focused on how we in Rhode Island can create a trauma informed system, and how do we train all staff in our various systems to identify and integrate knowledge of trauma into daily work. Jason Lang, Ph.D. in his presentation on Developing a Trauma-Informed System of Care, provided data on the financial cost of treating youth with trauma. The number of youth referred to court in RI in 2013 was 4,964 and 805 of these youth had trauma exposure.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.⁷⁹

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{80 81} Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁸²

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

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

⁷⁹ <http://csqjusticecenter.org/mental-health/>

⁸⁰ The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

⁸¹ A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

⁸² Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Justice

1. Are individuals involved in or at risk of involvement in the criminal and juvenile justice system enrolled in Medicaid as part of coverage expansion?

BHDDH - Rhode Island has a robust health insurance program through the Affordable Care Act for the expansion population. The Medicaid Division has worked closely with the Department of Corrections to provide access to health insurance for individuals being released. According to the Rhode Island Medicaid Division, during the first year of implementation of the Affordable Care Act, two thousand one hundred sixty-two (2,162) individuals exiting the prison system have been signed up for health insurance.

Rhode Island's expansion population receives access to the same health insurance programs as individuals who are eligible for Medicaid. Therefore, all health and treatment services that are available through Medicaid are available as individuals reenter the community from prison. The State of Rhode Island includes medication assisted treatment in its plan which means that Methadone, Buprenorphine, and Vivitrol are covered.

DCYF—For families whose youth involved in the juvenile justice system, DCYF staff provide families information about the state's system through HealthSource RI if they are not already enrolled or covered by insurance. If the youth is placed in a congregate setting, the youth will be covered while in placement by Neighborhood Health Plan of RI (NHP). Youth not in placement or at the RI Training School may be eligible for additional services covered under the 1115 Medicaid waiver which assists in the development and use of a community-based system of care.

2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

BHDDH - Through the JDTR grant individuals suspected of suffering from trauma, particularly members of the military are referred to court clinicians who screen for trauma. In addition the state funds staff to refer individuals with mental illness not related to trauma. Individuals who screen positive for trauma or mental illness are recommended for treatment or further assessment. Sometimes the recommendations lead to diversion from the criminal justice system and sometimes it means involvement in the Alternatives to Sentencing and Trauma Recovery program, which is part of the JDTR grant. If they are successful in the program they may get their records expunged, or get reduced sentencing.

In addition, two court clinicians work in the district courts to divert individuals with mental illness to treatment in lieu of the criminal justice system. Also, there is a Drug Court in each of the state's District Courts.

Screening and assessment for clinical substance use and mental health disorders is lacking in the present RIDOC reentry protocol process. If screening and assessments

were enhanced, more focused and detailed post release plans could be developed. Services for people leaving prison are often delayed because they must wait for clinical assessments to be administered post release before treatment can commence.

DCYF- Youth who are in the RI Training School waiting trial, are provided screening and evaluation services after 48 hours and before adjudication. There is a range of interventions customized to the needs of youth. The Training School maintains a system that combines independently validated risk assessments (GAIN) and a mental health screening instrument, Massachusetts Youth Screening Instrument Version 2 (MAYSI-2) with the professional judgment of multidisciplinary teams to assess individual needs and to identify risk factors that must be addressed. This system is utilized to inform family court and to guide a youth's movement within the juvenile justice continuum of care, which also includes Probation, the Youth Assessment Center, and the Youth Development Center, the Female Program, Temporary Community Placement and ultimately transition to the community.

DCYF also provides the Youth Diversionary Programs (YDP) which is a community-based program for youth between the ages of 9 and 17 who are at risk of being involved in the juvenile justice system. The goals of the YDP are to divert youth from the juvenile justice system and to prevent youth from involvement with DCYF. Crisis intervention, family mediation, advocacy, counseling and referrals are provided for up to 90 days. Four community agencies have provided services to 245 youth (from July 1, 2013 to June 30, 2014) FY 2014.

3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?

BHDDH - See Q2 for adults.

DCYF - Rhode Island has been chosen by the Annie E Casey foundation as one of their Juvenile Detention Alternative Initiative sites, with Rhode Island KIDS Count as the designated lead agency. DCYF Juvenile Correctional Services is being provided valuable technical support and resources through participation in this initiative to address the efficiency and effectiveness of juvenile detention. One of the goals is to eliminate the inappropriate or unnecessary use of secure detention. A Pre-detention Risk Assessment Tool and Procedure has been designed and is now being piloted to assist the courts, the criminal justice system and Juvenile Corrections in making timely and appropriate decisions prior to and hopefully instead of detention.

TRANSITION FROM PRISON TO COMMUNITY PROGRAM (TPCP):

Since early 2008, the Transition from Prison to Community Program (TPCP), in conjunction with the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), the Department of Corrections (DOC), the Rhode Island Parole Board and contracted substance abuse treatment providers have been working closely to

assist in the transition of inmates back into their communities by providing/coordinating substance abuse services to those individuals who are eligible for parole and in need of services upon their release from the ACI.

The Rhode Island Adult Drug Court has been in existence for about 11 years. Its purpose is to improve the quality of participant's lives in a timely and effective manner through substance abuse treatment, social services, and justice interventions, to help reduce the incidence of substance abuse among participants and decrease their involvement in the criminal justice system.

FAMILY AND JUVENILE DRUG COURT

The Family Court is committed to providing innovative rehabilitative services to Rhode Island's youth and their families. The creation of the Family and Juvenile Drug Calendar allows the judicial system to focus on a therapeutic approach as opposed to the traditional adversarial process. The Drug Calendar combines the persuasive and coercive powers of the juvenile court with clinical assessment and therapeutic interventions. Under the supervision of the Chief Judge of the Family Court, the Drug Calendar is the product of a collaboration among the offices of Family Court, Attorney General, Public Defender, Department of Children, Youth and Families, Department of Human Services, other state agencies, the legislature, as well as, members of business, minority, and community groups.

OFFICE OF THE ATTORNEY GENERAL – DIVERSION PROGRAM

The Adult Diversion Unit was established in 1976 as an alternative to prosecution for first-time nonviolent felony offenders. It enables qualifying offenders to accept responsibility and be held accountable for their actions while avoiding the stigma of a criminal record. The program offers the opportunity for the offender to earn the dismissal of criminal charge(s) by participating in drug treatment and mental health programs, providing community service at nonprofit agencies and paying restitution to the victims of these crimes.

DCYF—The Family Court may refer a youth to the Family Court Mental Health Clinic for an evaluation and a MAYSI-2 may be completed if needed. If the youth is being held in the training school, DCYF provides the needed mental health or substance abuse treatment that has been identified through the screening, evaluation and assessments provided by the program. An array of services is available at the time of reentry to help youth transition back to the community. These may include court ordered treatment such as MST, Preserving Families Network, Youth Transition Centers or temporary placement in a residential setting.

Youth Transition Centers (YTC): YTC is a public/private collaboration between Tides Family Services, Inc. and Juvenile Probation/Parole for high risk youth on probation or leaving the Rhode Island Training School. Youth receive services in the community with an emphasis on strengthening families by integrating outreach and tracking services from the Tides Family Services. YTC provides both prevention and rehabilitative services to around 85 youth per year.

4. *What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?*

BHDDH - Training needs/requirements vary from agency to agency. Trainings such as Motivation Interviewing/Criminal Justice, Integrated Assessment/Case Planning/Criminal Justice, Criminal Thinking and Relapse Prevention/Criminal Offenders are provided through various means such as the Drug and Alcohol Treatment Association and the New England School of Addiction Studies.

BHDDH strongly recommends and emphasizes qualifications for each clinical staff working with this population, at minimum, be a Licensed Chemical Dependency Professional (LCDP) and a Certified Criminal Justice Addictions Professional (CCJP).

The Rhode Island Department of Corrections has a contract with one of RI's licensed Opioid Treatment Programs (OTP) to provide clinical and medication services to incarcerated individuals with 6 months or less to serve. The RI DOC provides discharge planners for all inmates near release.

BHDDH and DOC have recently established an initiative providing an initial Vivitrol injection to willing participants within one month of anticipated release from incarceration. Partnerships have been developed with treatment providers to continue the treatment post incarceration.

Discharge planning at RIDOC is a two part process. The first phase begins six months prior to release with a discharge needs assessment. Pre-release planning staff also conducts various content groups that present information available in the community (e.g. employment and housing). The next phase begins 90 days prior to release. A post-release regional planner from the community where the inmate will be released is assigned. The regional planner will aid the transition and provide additional assistance in finalizing the discharge. The planner will follow the person up to 60 day post-release in the community. RIDOC contracts with discharge planning agencies covering the entire state. There is also specialized planning assistance through medical, mental health, substance abuse, and gang related vendor contracts. The internal case management process that identifies high risk individuals for priority case management is in place and operational.

The creation of regional Prisoner Reentry Councils is a critical piece of the state's strategy to accomplish our goals. The Councils include local stakeholders including police, community service agencies, institutional and community corrections officials, formal and informal community leaders, offenders themselves and their families. The Councils meet regularly to discuss policy issues and support case management of individuals released from prison. Participation of the local stakeholders is the essential element of a Reentry Council's ability to provide assistance for the transitioning people. The Department of Corrections is currently involved in eight councils in some of Rhode Island's core cities including: Providence, Warwick, and Pawtucket/Central Falls. These

cities already have a high concentration of people under probation or parole supervision and continue to receive high numbers released from prison.

BHDDH led an Offender Reentry Program application this spring to enhance the services and supports for Corrections staff, increase access to peer supports inside the prison and extend services into the community upon release. If awarded, the Department will focus on individuals ages 18-26 and connect them to Peer Recovery Specialists prior to release and potentially recovery housing through our current Byrne Jag program.

DCYF provides training through the CWI that address the mental health issues that is open to all staff of DCYF and community staff. DCYF staff also attend conferences such as the *Children, Trauma and the Integration of Care* which addresses need for integration of care across disciplines.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.⁸³

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.⁸⁴

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

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

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

⁸³ <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

⁸⁴ Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. *Psychiatric Services*. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

The Department would like to request technical assistance regarding joint communication strategies to individuals receiving care as well as health insurance payers.

Footnotes:

Parity

- 1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?*
- 2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?*
- 3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?*

The Department contracts with several organizations to provide advocacy and training to behavioral healthcare organizations. These contracts do not explicitly fund the oversight and education of parity.

BHDDH works closely with the Office of the Health Commissioner through the State Innovation Model grant and is educating staff on issues of parity.

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40⁸⁵, 43⁸⁶, 45⁸⁷, and 49⁸⁸. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

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

⁸⁵ <http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>

⁸⁶ <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>

⁸⁷ <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131>

⁸⁸ <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Medication Assisted Treatment

1. *How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?*
2. *What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?*
3. *What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?*

The State of Rhode has utilized Medication Assisted Treatment and through regulations and programmatic initiatives, such as the OTP Health Home, raised awareness of this treatment model with substance use disorder programs. Currently all residential treatment programs accept MAT and coordinate with and refer to MAT providers.

RI received CMS approval to implement peers in OTP Health Homes that require the integration of physical health care. All Block Grant funded programs coordinate with MAT programs, for example, the Respect Program was created to provide peer recovery coaches to address overdoses in emergency departments. All recovery coaches are trained on MAT and offer information and referrals to individuals on MAT programs.

BHDDH also collaborates with the Department of Health (DOH) in the following areas to address our Block Grant priority populations:

1. Coordinates with DOH in a neo natal abstinence syndrome committee.
2. Strategizes with hospitals on engaging pregnant women in opioid treatment.
3. Educates overdose survivors in MAT through recovery coaches and is enhancing this program to outreach to “hot spot” communities through data sharing with the DOH.
4. Requires OTP Health Homes to comply with federal and state mandates regarding MAT (5 agencies, 12 sites). All clients sign a consent for methadone treatment that informs of the affects and alternatives to MAT.
5. All programs must submit and maintain policies on diversion control. BHDDH audits this process which includes: report on call backs, submission of incident reports when medication is diverted.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁸⁹,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

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

⁸⁹Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Crisis Services

DCYF has a number of different initiatives that address the need for crisis services for children. As part of the contract with Neighborhood Health Plan of RI which covers children in placement, the health provider provides crisis services to the child/youth.

DCYF certifies ten provider agencies to provide Mental Health Emergency Interventions for Children. Each provider has a hotline that is confidential and free to families who will receive a call back within 15 minutes, and, if needed, a face to face assessment within two hours with a child competent clinician who can assess the situation and assist families toward the least restrictive option for appropriate care. Monthly data show that provider agencies received 2872 phone calls in CY 2014 and 926 were face to face mental health emergency interventions. These ten providers also reported seeing 3897 children and youth in CY 2014. 2461 or 63% were seen in a hospital setting.

One of the providers, Bradley Hospital, a children's psychiatric hospital, has initiated a state-wide call system based on a previous program sponsored by DCYF. Kid's Link RI is a hotline for children in emotional crisis offered in collaboration with a local CMHC, Gateway Healthcare. Kids' Link RI is available 24 hours a day, seven days a week for children suffering from behavioral problems or psychiatric illness. The hotline connects parents and caregivers to children's services in Rhode Island, and helps parents determine the best place to go for treatment and counseling.

BHDDH – has a number of initiatives that addresses the needs for crisis services for adults.

All of RI's six CMHC organizations provides, or make available, directly or through referral, crisis intervention and stabilization services for the individuals they serve. In addition to the individuals they serve, all CMHC's are required to operate a crisis intervention and stabilization program for adults who reside in the CMHCs designated service area and who do not have a current behavioral healthcare provider. CMHCs must ensure that emergency services are available via telephone and /or face-to-face evaluation twenty-four (24) hours a day, seven (7) days a week.

In addition, the state has three hospital diversion and step down, acute stabilization units. These units provides on-going assessment and observation, crisis intervention and psychiatric, substance abuse and co-occurring treatment. The Providence Centre operates 16 bed facility. Community Care Alliance operates a 13 bed unit. AdCare operates 23 dual diagnosis service beds for individuals with co-occurring substance abuse and psychiatric symptoms.

The Providence Center also provides a community diversion clinician for the Warwick and Providence Police Department. This clinician offers professional consultation to officers, identifies available resources to assist officers and members of the community and connects individuals to treatment, avoiding inappropriate, costly, and ineffective involvement with the criminal justice system or hospitalization.

Through its training contract with Rhode Island Council of Community Mental Health Organizations, BHDDH provides a police training through a Certified Crisis Responder Program.

BHDDH has created an Emergency Department Diversion program where Peers respond to overdoses in emergency departments to ensure there is education, support and follow up in the community for individuals who overdose.

The Department's Regulations for Behavioral Health Organizations (BHO) require all licensed agencies to have disaster and safety plans and crisis services. In addition, through the Rhode Island Council of Community Mental Organizations, provides Disaster Behavioral Health Responder Training Program. This is a jointly funded by BHDDH and the RI Department of Health (DOH). This training provides participants with the knowledge and skills required to provide effective post-critical incident behavioral health interventions in the community, and qualifies participants to be members of the Community Mental Health Organizations' Disaster Response Teams. Some examples of critical incidents include fires, hurricanes, ice storms, search and rescue, hazardous material accidents, and other serious accidents and/or deaths.

There are however, apparent gaps in the specific continuum of services which leads to extreme challenges for clients seeking comprehensive services. According to a recent Behavioral Health Need Assessment study (2015) conducted by Truven Health Analytics, Rhode Island hospitalizations per 100,000 hospitalization for mental and substance use disorders were higher than other New England States (FY 2010-2012). In addition, local emergency departments currently face an over utilization of high cost, high levels of non-urgent substance disorder and/or behavioral health usage that could be treated more effectively in alternative settings.

With Rhode Island's small geographic area and concentration of providers (often located within the Providence- metro area), the ability to track and coordinate services for individuals, the state feels a more integrated crisis response system can be created within existing resources.

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|--|---|--|
| • Drop-in centers | • Family navigators/parent support partners/providers | • Mutual aid groups for individuals with MH/SA Disorders or CODs |
| • Peer-delivered motivational interviewing | • Peer health navigators | • Peer-run respite services |
| • Peer specialist/Promotoras | • Peer wellness coaching | • Person-centered planning |
| • Clubhouses | • Recovery coaching | • Self-care and wellness approaches |
| • Self-directed care | • Shared decision making | • Peer-run crisis diversion services |
| • Supportive housing models | • Telephone recovery checkups | • Wellness-based community campaign |
| • Recovery community centers | • Warm lines | |
| • WRAP | • Whole Health Action Management (WHAM) | |
| • Evidenced-based supported | | |

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

We are interested in TA that would help peer organizations to become more self-sufficient and help BHDDH develop outcomes-based contracts that would be appropriate for peer organizations

Footnotes:

Recovery

1. *Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?*

The following recovery definition was developed by the BHDDH-sponsored Recovery Workgroup. Included are recommendations from the Recovery Focus Groups; Recovery Surveys; Recovery. Discussions at licensed behavioral healthcare organizations; and excerpts from works by William A. Anthony and Patricia E. Deegan. This definition has become a part of the Department's Regulations:

Recovery is a journey that results in a person accepting and overcoming the challenges of a disability. Throughout this journey, the person may arrive at meaning, purpose, value, and a comfortable sense of self. Every journey is made up of a different collection of experiences.

Recovery in a major mental illness or addiction to alcohol and other drugs does not usually mean cure of the illness, but adaptation that allows life to go forward in a positive way. Adaptations happen in the individual and in the environment. Recovery is so deeply personal. Supportive people, especially peers, can help it take root, but none can bestow recovery. It springs from a lighted clearing in the deep woods; it ascends from the healing self.

Each BHDDH-licensed organization/facility providing behavioral healthcare services in Rhode Island shall meet the following Recovery Standards:

- Mission statement of the organization identifies recovery vision as driving the system
- Organization includes people who receive services in all phases of service planning and evaluation
- Primary outcomes identified for each service provided by the organization include measures of recovery
- Leadership of the organization reinforces recovery vision and recovery standards
- Policies and procedures of the organization are compatible with recovery values
- Organization provides access to an array of services so that recovery plans may
- be effectively individualized
- Organization provides training to improve knowledge, attitudes and skills necessary for all staff to conduct recovery-oriented services.
- Organizations shall promote recovery and empowerment by recognizing the uniqueness of each person receiving services and supporting the individual's:
 - Expressed desires
 - Strengths
 - Choices and self-determination
 - Self-management of her/his illness

- Direction of her/his treatment plans and service process.

Organizations shall offer services that ensure the opportunity for each person receiving services to attain the following service outcomes:

- An understanding of their behavioral health issue and the recovery process
- A belief in their own recovery
- Improved self-esteem
- Physical well-being
- Supportive relationships with family and peers
- Adequate resources to sustain a good quality of life
- Optimal functioning
- A safe and comfortable living environment
- Self-management of symptoms
- Knowledge of community resources and benefits/entitlements
- Engagement in daily activity that is meaningful to the person, e.g., employment; educational options; hobbies; initiatives of personal interest; supportive, structured activities etc.

Organizations shall ensure that staff who supervise or provide direct services shall demonstrate the following:

- A belief in recovery
- An understanding of recovery as a personal journey that takes time; not a onetime event
- Respect for the uniqueness and autonomy of each individual
- Adequate emotional intelligence to cultivate hope, confidence, and perseverance in persons receiving services
- Capacity to develop a positive, trusting relationship and to work in partnership with others
- An ability to incorporate a person's social and cultural environment into the recovery process
- An understanding of the benefits of mutual peer support in the recovery process.

The state's recovery services plan was developed by the Recovery Subcommittee of the Governor's Council on Behavioral Health and adopted by BHDDH in 2010. Its recommendations included:

- 1.1. Create a permanent ROSC Advisory Group that will assist organizations to enhance their recovery-oriented services. Group activities would include:
- 1.2. Establish two Task Forces that will report to the ROSC Advisory Group
 - 1.2.1. Create a Recovery Access Task Force to identify and diminish the barriers to:
 - Integration of prevention, treatment and recovery support services
 - The ability of these services to enhance the delivery of a recovery-oriented system of care.
 - 1.2.2. Create an Employment Task Force to focus on the enhancement of existing, and the development of new, employment opportunities

- 2.1 Require prevention, treatment and recovery support services cross trainings for all licensed and contracted providers to:
 - 2.1.1 Provide a common knowledge base about the continuum of recovery-oriented care
 - 2.1.2 Establish personal connections among the providers of the service continuum
- 2.2 Provide training and education in recovery principles for clinicians, case managers, family members, and for faith-based and other alternative community service providers
 - Establish a Recovery Research Center (RRC) that identifies Rhode Island program best practices (in prevention, treatment and recovery) that support recovery
 - The RCC will be the Rhode Island registry of effective programs and practices.
- 2.3 Change the Behavioral Healthcare Licensing Regulations to:
 - 2.3.1 Allow recovery groups to be conducted by peers
 - 2.3.2 Move from a treatment plan to a recovery plan
 - 2.3.3 Require that providers enhance their strategies for linking clients to appropriate communities of recovery, based on mutual agreement between the clinician and the client of the client's needs and based on client choice
- 2.4 Develop a mental health crisis diversion/respice program drawing from existing national models
- 2.5 Provide peer services in both hospital Emergency Departments and in inpatient settings; services would be provided by persons living with mental illness and/or families of persons living with mental illness
- 3.1 Enhance and expand existing peer group programs
- 3.2 Establish peer specialists at the various community mental health & other treatment facilities
- 3.3 Support for the certification of Peer Recovery Specialists (Combined Certification for Mental Health and Substance Use Disorder Peers established as of 1/1/15 with The Rhode Island Certification Board which is affiliated with IC&RC.)
- 3.4 Convene a conference on the value of peer services
 - Endorse the new Ocean State Coalition for Recovery Housing (OSCRH) The existing coalition is in the process of developing voluntary standards.
 - The intent of OSCRH is to move the present sober housing model to a more integrated recovery housing model.
 - Enhance the existing behavioral healthcare hot lines and warm lines to allow a live personal contact at any time The RICAODD hotline presently goes to an answering service at midnight. Rather than use the service, calls would be transferred to the 24 hour residential substance abuse programs that already have overnight staff.
 - Increase the involvement and the integration of the faith-based recovery movement into the prevention, treatment and recovery continuum Faith Infused Recovery Efforts (FIRE) is a new coalition that is meeting regularly. They are interested in receiving trainings, providing trainings, and resource information exchange.
- 4.1 Require the Substance Abuse Prevention Task Forces to actively recruit membership from the recovery community
- 4.6 Create a ROSC Rhode Island Alumni Association (ROSC RIAA) This will be an easily accessible, statewide peer support system for all clients who are leaving treatment, returning to treatment or transitioning to a different level of care.

- Each treatment organization will develop its own chapter
- The ROSC RIAA will develop and maintain an interactive website
- Regular events such as Recognition Awards Breakfasts and an Annual Event for all alumni would be held

2. *How are treatment and recovery support services coordinated for any individual served by block grant funds?*

- Opioid Treatment Provider Health Homes peers
- BH Health Homes peers
- Emergency Room OD peer project (“AnchorED”)
- Anchor Community Center services
- BHDDH is working on developing an infrastructure to coordinate, monitor and expand peer recovery services in Rhode Island through BRSS TACS funding.
- BHDDH monitored Waiting list
- Soon to be state certification of recovery housing (State legislative resolution 2015)

3. *Does the state’s plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?*

RI Certified Peer Recovery Specialist are required to be recertified every 2 years with 20 hours of continuing education. It is anticipated that continuing education classes will be designed to address the need of specific populations such as veterans, trauma, LGBT, etc
Current peer services;

- OD survivors met at the hospital by peers on-call 24/7 days a week to support and offer recovery services and follow up. (The AnchorED program)
- Family members of Overdose survivors meet with family members of OD survivor at the hospital and provide follow up support for Nar-anon or all-recovery faith based groups.
- Trauma/veterans in Kent County court diversion project and at the VA
- Youth/young adults and family members in the Healthy Transition CSC treatment program will receive peer services to help with first identified psychotic break. The 5% MHBG set aside for prevention of SMI will be used to train and support the activities of the youth peer support staff who will be part of the CSC treatment teams.
- Family support programs (Parent Support Network) for families of children with SED
- Youth Pride, an organization for LGBT youth and young adults
- The RI Coalition of Overdose prevention and rescue team (BHDDH and DOH) trains and deliverers Narcan to community overdose “Hot Spots” using peer volunteers.

4. *Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?*

BHDDH is in the midst of major advances with regard to Peer Recovery Services. Over the past eight years, the Department and its community advisory group has enhanced its work on the peer services, which included the initial training of substance abuse Recovery Coaches (2007), the

first training of Peer Specialists to support people with mental illness (2012), the certification of mental health peer specialists by BHDDH (2012), the Rhode Island Certification Board's development of a certification for Peer Recovery Specialists and the receipt of SAMHSA/BRSS TACS awards in 2014 and 2015. The current advances are mostly due to BRSS TACS and a new approach to funding for Mental Health Peer Recovery Services. Both are briefly described below.

BRSS TACS

BHDDH is currently leading a Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Academy project team. The focus of this project is to increase the availability of competent Peer Recovery Support Services and ensure adequate funding for Peer Recovery Support. The Rhode Island BRSS TACS team is composed of peers, behavioral health community leaders, providers, advocacy agencies, academicians and representatives from the RI Medicaid office, Department of Health and Certification Board. To date, the BRSS TACS team has accomplished the following:

- Completed a Behavioral Health Peer Recovery Specialist job description for Medicaid which part of an 1115 Medicaid Waiver application pending at EOHHS.
- Developed an integrated Mental Health/Substance Use Disorder Peer Recovery Specialist curriculum designed to be co-taught by mental health and substance use disorder peers. This curriculum will be piloted in June, 2015.
- Developed a questionnaire for measuring outcomes of an integrated peer recovery training and certification process
- Adopted an integrated Peer Recovery Specialist certification process, effective, 1/1/15. (Prior to BRSS TACS, Mental Health and Substance Use Disorder PRSs had different certification processes.)

By September 2015, RI BRSS TACS plans to implement data collection systems to better understand outcomes associated with:

- **consumers** seeking assistance from a peer recovery specialist and
- **peer recovery specialists** working within Rhode Island's recovery-oriented system of care for substance use and mental health services.

4. *Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?*

As stated above, RI BRSS TACS is developing and will be implementing data collection systems to better understand outcomes associated with:

- **consumers** seeking assistance from a peer recovery specialist and
- **peer recovery specialists** working within Rhode Island's recovery-oriented system of care for substance use and mental health services.

5. *Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals*

and families, opportunities for individuals and families to be proactive in treatment and recovery planning).

- An all-day RI Mental Health Summit was held on June 6th, 2015. Rhode Islanders were invited to participate in process of addressing planning, delivery, and evaluation of RI's behavioral healthcare services. Two hundred and fifty people attended and offered suggestions that are now leading to re-inventing Medicaid products and enhancing existing services. The Department had three thought provoking presentations with solution focused workgroups following each presentation. The three presentations were; Marwin Haddad, MD on "The Opioid Epidemic", Dr. Dale Klatzer on "Health Disparities" and Dr. Daren Anderson on The ECHO program and utilizing e-Consult services at three of RI's FQHC's. The lightning round responses continue to be available on the BHDDH website for comments and review.
- Multiple community forums have been held to address the RI Opioid overdose epidemic. The forums were held at various locations; town halls, YMCA, Recovery Community centers, all have been held to hear from families and individuals personally affected by the overdose issue and recovery supports that are available.
- DCYF's FCCPs have regional (4) Family and Community Advisory Boards made up of community partners, parents and youth. In addition there is one Statewide FCAB. The design is to ensure a flow of information, promoting open dialogue among the FCCPs and external stakeholders. Involving more Youth and family participation in the FCAPs has been one of the tasks of the SOC Implementation Cooperative Agreement.
- Family members and Individuals in recovery are active participants of the Governor's Behavioral Health Council, the Governor's Overdose Task Force and the BRSS TACS training program for recovery peers in the state.

6. *Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?*

- The MHBG helps fund many of the behavioral health advocacy programs in the state including. MHARI, MHCA, Anchor, and NAMI-RI. The MHBG also provides some funding for peer support for families and youth through a family based organization.

7. *Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.*

- All programs funded via contracts with the state are required to provide regular quarterly reports as part of the contract deliverables. For example, the AnchorEd peer program supplies monthly reports on client contacts, follow-up supports and referrals to treatment as necessary. This same report allows the Department to track state trends. This is the same requirement for NAMI-RI. OASIS, MHCA etc.

9. *Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.*

All Health Home services whether they be in the CMHO clinics or the Medication Assisted Treatment programs are the fixed point of responsibility to coordinate and ensure the delivery of **person centered care**; provide timely post discharge follow-up, and improve patient health outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers of comprehensive, integrated services. Emphasis is placed on the monitoring of chronic conditions, and preventative and education services focused on self-care, wellness and recovery. This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits

10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?

The CMHOs have had supported housing for their CSP clients for many years. Several years ago, as described in more detail in the Olmstead section 18, BHDDH adopted a Housing First policy. This policy has been extended through an 811 Award for 150 housing vouchers that include supportive services, EOHHS' Money Follows the Person program and Person Centered Planning Transition Plan for Home and Community Based Services. These initiatives take place in the context of the state Continuum of Care's (COC) plan, "Opening Doors R I," and the COC's adoption of a "Zero 2016" program. Access to all housing/service vouchers for chronically homeless individuals is through a common wait list prioritized according to vulnerability determined by the VI-SPDAT. As a result, severely behaviorally disordered individuals are given high priority for housing and support services. BHDDH is an active participant in the COC and also administers the state's PATH grant, which increases access to housing and services for individuals with SMI and COD.

11. Describe how the state is supporting the employment and educational needs of individuals served.

The Department is committed to helping adults with disabilities achieve self-sufficiency through work readiness, work force development and job creation. In order to achieve the intent outlined in the framework of this Employment First Policy, employment opportunities in fully integrated work settings shall be the first and priority option explored in the treatment plan for working age adults with mental health and/or substance use disorders in Rhode Island. While all options are important and valued, integrated employment is more valued than non-employment, segregated employment, facility-based employment, or day habilitation in terms of employment outcomes. For those who successfully achieve the goal of employment in an integrated setting, future service planning must focus on maintaining employment as well as the consideration of additional career or advancement opportunities. For those not yet achieving employment, annual service planning shall include and reflect employment opportunities as the first and priority service option explored. The behavioral Health Homes teams are required to include a certified Supported Employment Professional. SEPs are trained as part of BHDDH's training contract with the RI Coalition of Community Mental Health Centers.

SAMHSA grant-funded Healthy Transitions program requires that the two treatment teams for youth/young adults include educational/employment specialists to work aggressively to get clients back into school or employment following their first episode of SMI.

RIC included Peer Recovery Specialists in a Real Jobs RI Planning grant which was awarded in August, 2015. This is a multi-agency partnership to create a plan to address healthcare workforce needs.

DCYF's FCCP program provides services to children and families not involved with the department through the use of wraparound facilitation. The philosophy and values of wraparound promotes the use of youth, family, and community in working together to help the child/youth. Family Support Partners and Peer Support through parent organizations are available to help and support parents with children with special needs and those having difficult navigating the housing support and services in the community.

12. Does the state have a plan for ongoing peer support provided by peer-run and family organizations?

BHDDH and EOHHS have been working to establish funding for peer support services through the 115 Waiver, which will enable peer organizations to provide more peer support services. Currently, Block Grant funds help support Anchor, PSN, MHCA-RI and NAMI. Currently, there are a number of peer-run organizations which provide peer support services:

- Mental Health Consumer Advocates of RI (MHCA-RI), which runs the OASIS Wellness and Recovery Centers, is a peer-run, grassroots organization for individuals in recovery from mental illness. Rhode Island MHCA-RI promotes recovery in multiple ways. The OASIS Centers provide a place for adult Rhode Islanders living with mental illness to recover in a supportive environment. Recovery activities include support groups that provide members a safe place, either short or long-term, to overcome difficult issues such as trauma, anger and paranoia and move forward in their lives. The Art program gives people a social venue in which to express their creativity and interact with their peers.

MHCA-RI has reached out to CMHO's and local psychiatric hospitals for referrals and to offer peer support to residents in the hospitals

MHCA-RI has offered multiple trainings at the OASIS that prepare people to embrace their own recovery and work in the mental health field as peers. These trainings include Certified Peer Recovery Specialist (CPRS), Intentional Peer Support (IPS), Wellness and Recovery Action Plan (WRAP), and Whole Health Action Management (WHAM). Further trainings are planned in Group Facilitation and CPRS Ethics.

All OASIS activities are free of charge and supported by Block Grant funding. All of the OASIS board members and staff, with the exception of two advisory board members, are people living in recovery with mental illness.

- The National Alliance on Mental Illness of RI (NAMI-RI) offers education, support and advocacy on behalf of people living with mental illness and their families. NAMI-RI has several 12 week Family-to-Family classes each year that are taught by trained family members who have previously taken the course. These classes open participants' eyes

regarding what to expect with mental illness of a family member and assure them that they are not alone. Class members often follow up by joining NAMI Family Support Groups.

NAMI-RI has a number of NAMI Connection Recovery Support Groups that offer ongoing help to adults in Rhode Island living with mental illness. NAMI-RI is reviving its 10 week Peer-to-Peer classes, which will be taught by trained people living in recovery with mental illness. These groups orient members to successful living with mental illness.

NAMI-RI intends to introduce Parents and Teachers as Allies program that will help students living with mental illness get the support they need in and out of the classroom. For a number of years, NAMI Rhode Island has had a program called Inside Mental Illness (IMI), where people living with mental illness teach about mental illness in high schools, colleges, hospitals, and more. Seeing the teachers living successfully with a mental illness gives the students much-needed support.

Most of the NAMI-RI staff are people living in recovery with mental illness and most of the board members have a family member living with a mental illness, although there is some overlap. All NAMI-RI activities are free.

- Parent Support Network of Rhode Island is a family-run and youth-guided organization that serves Serious Emotional and Behavioral Disturbances, Juvenile Justice, Mental Illness/Mental Health, Substance Abuse population.
- There are a number of other community agencies that provide support and services that incorporate family to family support and advocacy that reflect the value of voice and choice in DCYF's system of care
- Anchor Recovery Center is a peer-run recovery community center that runs seven days a week from two locations in Rhode Island. It provides a variety of sober social activities and events, job search and coaching assistance, AA and NA meetings and other groups, and peer recovery coach activities, including AnchorED.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Rhode Island has been part of several SAMHSA Olmstead TA projects. However, we need assistance in the development of a plan and building the will of our partner state agencies (Medicaid, Office of Housing) to adopt a plan.

Footnotes:

Olmstead

BHDDH

1. *Describe the State's Olmstead Plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.*

In October 2013 Rhode Island's Department of Behavioral Healthcare, Developmental Disabilities and Hospitals hosted a 2 day summit on Olmstead Planning supported by SAMHSA's technical assistance consultants from Advocates for Human Potential. The attendees included representatives from the Office of Housing and Community Development, RI Housing, Medicaid's Money Follows the Person program, community advocacy groups and trade associations from related fields, including homelessness, housing and behavioral health and BHDDH's Research and Data, Planning and Behavioral Health units.

The team created a SWOT Analysis to identify our Strengths, Challenges, Opportunities, System Threats and next steps. The State does not have an officially adopted Olmstead Plan, however, there is an integration philosophy that crosses through the programs and initiatives across the state.

The State has submitted its Home and Community Based Services plan for integration and is in the process of doing a provider survey to determine where to prioritize training and technical assistance to come into compliance by 2019. Please see the answer to question 3 for more details.

2. *How are individuals transitioned from the hospitals to the community?*

The Executive Office of Health and Human Services administers a Money Follows the Person Programs as well as a Nursing Home Transition Program that works to move individuals from hospitals to nursing homes and the community. All hospitals have discharge planners that work closely with the state departments to move individuals to the least restrictive setting. Rhode Island Housing, BHDDH and the EOHHS received an 811 award of 150 housing vouchers in 2015, we are in the initial stages of planning and awaiting the HUD contract. These vouchers will house individuals who are served by BHDDH, the Money Follows the Person program and individuals experiencing chronic homelessness.

3. *What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?*

Money Follows the Person: The Executive Office of Health and Human Services (EOHHS) received a Money Follows the Person award through the Center for Medicaid Services to address how individuals in Long Term Care Medicaid transition from institutions into the community and give people with disabilities and re-balance its LTC funding towards community based care.

Person Centered Planning: The Executive Office of Health and Human Services (EOHHS) led the process in developing a Transition Plan for services funded through what is traditionally the Medicaid

Home and Community Based Service (HCBS) waiver. Rhode Island has one 1115 Waiver that provides HCBS, however, the State is submitting a Transition Plan to the Center for Medicaid Services (CMS) that will ensure that all services across age ranges and disabilities will be integrated in the community by March 2019. Included in the State's Plan is a provision for monitoring and technical assistance for community providers.

811 Award: Rhode Island Housing, the EOHHS and BHDDH applied for and was awarded 150 housing vouchers for individuals experiencing chronic homelessness, individuals with Behavioral Health disorders who would like to live in the community and individuals who are transitioning from nursing homes in the Money Follows the Person program. This program combines affordable housing with supportive services to allow individuals to live in the least restrictive setting in the community. The 811 units are typically part of a larger affordable housing development and are no more than 25% of the overall units in the development.

The Department believes that housing and employment are the foundation for recovery and have developed the following policies to ensure housing and employment services are prioritized throughout the work of the Department. BHDDH's Housing First and Employment First initiatives are examples of the Department's commitment to the philosophy of community integration across its Divisions (Behavioral Health, Developmental Disabilities and Hospitals). Due to the diversity of its populations and the expanse of treatment options - from hospital care to detoxification to group homes and supportive housing - BHDDH has the supports and health care options to demonstrate savings across the Department's divisions and improve budgets across State Departments. In order to bring our work to scale, we must invest in the solution and re-invest a portion of the cost savings to effect a long term system change.

Employment First: The Department is committed to helping adults with disabilities achieve self-sufficiency through work readiness, work force development and job creation. In order to achieve the intent outlined in the framework of this Employment First Policy, employment opportunities in fully integrated work settings shall be the first and priority option explored in the treatment plan for working age adults with mental health and/or substance use disorders in Rhode Island. While all options are important and valued, integrated employment is more valued than non-employment, segregated employment, facility-based employment, or day habilitation in terms of employment outcomes. For those who successfully achieve the goal of employment in an integrated setting, future service planning must focus on maintaining employment as well as the consideration of additional career or advancement opportunities. For those not yet achieving employment, annual service planning shall include and reflect employment opportunities as the first and priority service option explored.

Housing First: Housing First provides an opportunity to address a structural systems issue in RI regarding homelessness and the over-utilization of emergency room departments and expensive emergency services. In 2005, the state of Rhode Island and the United Way of Rhode Island created a pilot program to address chronic homelessness in the State by housing homeless, single adults in subsidized apartments and providing those clients with the services they needed to stay housed. The program was designed according to "*Housing First*" principles which involve rapid access to permanent housing with voluntary access to a variety of services that focus on housing retention. The program was implemented in 2005 and an evaluation of the program by Eric Hirsch, PhD and Irene Glasser, PhD, in July of 2006 found a substantial cost savings to the State, approximately \$7500 per person per year. This is similar to what states across the country have found when Housing First is implemented.

These cost savings can only be realized if clients remain in their new homes. A return to life in the street or in shelters is destructive to a client's physical health, mental health, and level of social integration.

And, it dramatically increases the costs to the government and taxpayers due to increased use of health, mental health, corrections, and shelter facilities. BHDDH is committed to expanding housing retention services and housing options for the population we serve. We are collaborating with Rhode Island Housing, the Office of Housing and Community Development, Medicaid, Corrections and the Department of Human Services to find innovative solutions to the lack of supportive housing statewide.

RI Department of Corrections Discharge Planning: BHDDH works closely with the Department of Corrections to establish community based treatment and recovery housing for 30 individuals through the Byrne Jag program. This spring we collaborated on the Offender Reentry Program grant to expand behavioral health and recovery services to individuals in prison and as they are released into the community. We are awaiting notice as to whether we will receive the grant.

Peer Support Services: BRSS TACS BHDDH is currently leading a Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Academy project team. The focus of this project is to increase the availability of competent Peer Recovery Support Services and ensure adequate funding for Peer Recovery Support. The Rhode Island BRSS TACS team is composed of peers, behavioral health community leaders, providers, advocacy agencies, academicians and representatives from the RI Medicaid office, Department of Health and Certification Board. To date, the BRSS TACS team has accomplished the following:

- Completed a Behavioral Health Peer Recovery Specialist job description for Medicaid which part of an 1115 Medicaid Waiver application pending at EOHHS.
- Developed an integrated Mental Health/Substance Use Disorder Peer Recovery Specialist curriculum designed to be co-taught by mental health and substance use disorder peers. This curriculum will be piloted in June, 2015.
- Developed a questionnaire for measuring outcomes of an integrated peer recovery training and certification process
- Adopted an integrated Peer Recovery Specialist certification process, effective, 1/1/15. (Prior to BRSS TACS, Mental Health and Substance Use Disorder PRSs had different certification processes.)

RI Continuum of Care is one of the only statewide continuums of care across the country that is the planning body for the state in the area of homelessness,

The Rhode Island Continuum of Care recognized the need for a statewide SSI/SSDI, Outreach, and Access to Recovery (SOAR) program in 2005 at the time the Housing First pilot was being developed. A subcommittee was formed to investigate expanding the current SOAR program, which was part of the ACCESS program with a plan to bring the effort to scale statewide and identifying sustainable funding. The United Way of Rhode Island and the Consolidated Homeless Funds (administered through the Office of Housing and Community Development) piloted the statewide SOAR program and required that all agencies requesting funding incorporate the SOAR initiative into their work. The Statewide SOAR staff developed relationships with the Disability Determination Services (DDS) at the RI Department of Human Services, trained case managers from homeless service providers and community mental health centers and worked collaboratively with case managers from agencies across the state to move forward applications to DDS. This process has worked exceptionally well and will continue through this project. The SOAR staff work with agency case managers to complete the SSI/SSDI application process and the statewide SOAR staff check for completeness and act as a liaison to the State Disability Determination program. Due to the established relationship, the

applications are expedited and the RI SOAR program has a quick turn around and a consistently high approval rate.

The Department has certified Supported Employment Specialists in its licensed community mental health centers. The lead agency awarded the sub-contract for this project will devote a full-time certified Supported Employment Specialist to assist individuals in gaining employment and training opportunities. The services the Supported Employment Specialist provide include: job development, job coaching and job retention and connection to mainstream resources through the State's One Stop Centers. BHDDH has implemented an Employment First policy for individuals across disabilities and is working with training and technical assistance providers, the Office of Rehabilitative Services and the Department of Labor and Training's Disability Employment Initiative as well as the Governor's Workforce Board's Career Pathways program to increase employment opportunities for individuals with disabilities.

It is anticipated that at the time this project commences Peer Recovery Specialists in Rhode Island will have third party reimbursement. They will be able to work with agencies to outreach to those with behavioral health issues and assist with connections to SOAR.

4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved

There is currently no litigation for children with SED or adults with SMI. However, the State of Rhode Island entered into a statewide Consent Decree in 2014 regarding transitioning youth with Intellectual and Developmental Disabilities (I/DD), adults with I/DD in shelter workshop and segregated day programs.

5. Is the state involved in a partnership with other state agencies to address community integration?

BHDDH works closely with the Division of Medicaid, the Office of Rehabilitative Services and the Department of Labor and Training's Governor's Workforce Board. The Department participates in work groups and Advisory Groups that meet monthly to address access to employment, expanding resources and implications of incentives should as the Medicaid Buy In program and the Ticket to Work. We Department fund training and technical assistance to community based organizations that focus on supported employment and certification in this area.

The Department collaborates with the Office of Housing and Community Develop and Rhode Island Housing to increase the development of integrated affordable housing for individuals with disabilities through its Thresholds program and by participating in leadership roles within the Continuum of Care. BHDDH also partnered with Rhode Island Housing and EOHHS on an 811 application and was awarded 150 housing vouchers to integrated permanent supportive housing into larger affordable housing developments.

BHDDH also is working closely with the Department of Corrections to ensure that relationships with community providers are developed priority to release and access to services occur upon re-entry back into the community. The Department has applied for an Offender Reentry Program grant through SAMHSA that would enhance the current Discharge Planning process and incorporate Peers into the Discharge Planning Team.

DCYF

Homeless youth

- 2015 Rhode Island KIDS COUNT Factbook reports that the National Runaway Switchboard handled 104 crisis-related calls regarding youth ages 21 and under who were homeless, runaways or at risk of homelessness in RI during calendar year 2013. There were 52 youth in the care of RI DCYF between the ages of 13 and 20 who were reported as being runaways or on unauthorized absences from either foster care or juvenile justice placements. In 2014, the adult emergency shelter system in RI provided services to an estimated 97 single youth, age 18-20 and 266 young adults age 21-24 which was a significant increase over the previous year of 50 youth and 179 young adults.
- KIDS COUNT Factbook also reported that 535 families with children used emergency homeless shelters, domestic violence shelters, or transitional housing. This included 986 children. Many families involved with FCCP and DCYF have housing issues.
- DCYF continues to take a leadership role within the state's Housing and Homelessness Prevention Community. DCYF's Director, is a member of the Interagency Council on Housing and Homelessness. Mike Burk, Assistant to the Director, sits on various policy and implementation committees addressing Housing and Homelessness and chairs the External Grievance Committee, which hears grievance appeals from individuals and families who are involved with the state's adult and family shelter system, for the state's Office of Housing and Community Development.
- YESS Model Aftercare Program Services is collaborative effort with four community providers and DCYF, the YESS program has been expanded to include youth to age 18 to 24 for supportive housing services. This program is available to youth at risk of homelessness with documented mental health issues. This program enables these young people to remain in a low cost rental unit after they reach age 24.

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.⁹⁰ Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁹¹ For youth between the ages of 10 and 24, suicide is the third leading cause of death.⁹²

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁹³ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

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 substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.⁹⁴

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care⁹⁵:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

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

⁹⁰ Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

⁹¹ 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.

⁹² 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.

⁹³ The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁹⁴ 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 <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

⁹⁵ Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Children and Adolescent Behavioral Health Treatment Services

1. *How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?*

DCYF is the state's SMHA for children and adolescents. BHDDH is the SMA for adolescents. DCYF has adopted the system of care philosophy which reinforces the value of individualized care planning.

2. *How has the state established collaboration with other child-and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?*

DCYF is one of a few state agencies that is a unified state agency with combined responsibility for child welfare, children's behavioral health and juvenile corrections. DCYF has been developing a system of care for children, youth and families over the past twenty years with the help of various grants and special initiatives to establish a true collaboration to meet the behavioral health needs of children.

3. *What guidelines have and/or will the state establish for individualized care?*

DCYF has adopted the system of care philosophy which reinforces the value of individualized care planning.

BHDDH -The recently awarded Rhode Island Youth Treatment Planning grant will allow the State the opportunity to create a blueprint for the creation of a unified, recovery focused service approach for youth ages 12-25 with substance use disorders and/or co-occurring substance use disorders or mental health conditions. The Department has identified goals and objectives around the current gaps, norms, policies and resources that will, when coupled with the required interagency council and its subcommittees, improve access to and quality of services.

The key feature to our plan is the re-invigorating of the Children's Cabinet which will be essential to implementing the goals and objectives of the project. The current system is siloed and fragmented. The project proposes to systematically address the system's breakdown at the highest level of State Government, to develop policies (from programmatic reform to health insurance parity), fiscal supports, and the workforce capacity necessary to carry out the goals and objectives. The strategies will allow the State Departments to leverage collective resources, ensure that the voice of individuals served and their families in the development of policies and practice and the exploration of appropriate statutory response.

This goals of this project include: 1)building and funding an integrated service continuum (screening, referral, assessment and evidence-based interventions and supports) guided by principles and practices that are recovery focused, person-centered, culturally competent, trauma

and evidence informed; 2) building the knowledge, skills and abilities of a coordinated, culturally competent, trauma informed, recovery oriented workforce; 3) raising awareness through social marketing to change parental and societal norms that are favorable toward substance use. The project will also include the following activities: 1) creating a plan to expand the current provider collaborative; 2) creating a three year plan to bring together a Family and Youth Coalition; 3) incorporating the Department of Child, Youth and Families and BHDDH to leverage resources, collaborative structures and lessons learned and 4) developing policies to support service system and individualized workforce goals.

Through thoughtful planning and identification of strategies related to the above goals the State will be able to address barriers to accessing treatment and insure that evidence based treatment practices are age and culturally relevant and individually appropriate in response to our state's changing demographics.

The other recently awarded youth grant titled, "Healthy Transitions RI" will address the needs of 2500 youth and young adults ages 16-25 with Serious Emotional Disturbance Severe Mental Illness and/or Co-Occurring Disorders in two Rhode Island communities. Responsibility for these young people is divided between state agencies, service providers, families and others. This proposal seeks to develop a shared "locus of responsibility" responsible for their successful care. It proposes an interdepartmental administrative body, the Transition Team, advised by a Statewide Advisory Council composed of young adults, families, advocacy groups, state departments and service providers. Two cities, Warwick and Woonsocket, Rhode Island, will build on existing partnerships with youth and family representatives, local service provider agencies, educational, recreational, church and other community stakeholders to do several things. They will build 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 COD and, through the cities' two Community Mental Health Organizations, provide specialized intensive services to those who are experiencing SMI/COD. These services will involve a number of Evidence Based Practices delivered within the Coordinated Specialty Care (CSC) model.

The proposal's goal is to transform a divided service system that provides different types of services, using different eligibility criteria, to youth/young adults of different ages. Achieving the goal involves making structural changes at both state and local community levels. These changes will be measured in terms of the numbers of service agreements, policy and practice changes made at the state and city level and by the implementation of funding arrangements that can sustain this effort beyond the life of the grant. The proposal's other objective, the transformation of the service delivery system, will be measured by the total numbers identified through the outreach and engagement services as being at risk for SMI/COD and the total numbers served by CSC services. The program will outreach, screen and identify 2500 individuals over the five years of the grant. Of these, 700 will receive a clinical assessment and, of these, 500 will receive full CSC services, over the five year period

RI currently has a full continuum of treatment services for youth that reflects the adults system to treat behavioral health disorders; i.e. outpatient, in-patient, intensive outpatient treatment, residential and aftercare services. There is however limited peer recovery supports.

The Department has recently engaged youth and young adults in the Rally4Recovery yearly community advocacy event. There are 2 youth coordinators for the Rally that have the specific goal of engaging youth in state recovery activities with the hope of building a youth peer organization.

Youth Gaps identified in the current system include:

1. SBIRT Screening.
2. Outreach through pediatricians.
3. Centralized intake and assessment
4. Communication between schools and community prevention groups.
5. Workforce development
6. Outreach for youth and young adults not in school.

4. *How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?*

Various organizations that provide prevention, treatment and recovery services for children/adolescents and their families are working at providing training to their own staff and through collaboration to the organizations that comprise the system of care for children/youth and families. DCYF has been working collaboratively with the Networks of Care, the FCCPs, and the community organizations to educate and inform the system of the various programs and services available and to assist when possible in providing funding for start up costs and training on evidence-based services.

5. *How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?*

At present, there are different tracking systems being used to track the cost of services and outcomes for children and youth with mental, substance use and co-occurring disorders. DCYF has its own system as does the health system and BHDDH. This is based in part on the different payment streams and systems. There are a number of state wide initiatives that are addressing the need to have one data warehouse with all the information available in order to evaluation the total system for cost and outcomes.

6. *Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and /or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?*

DCYF has assigned Lori DiPino, Educational Services Coordinator, DCYF, 401-528-3833 as the liaison for DCYF with the Department of Education (DOE). DCYF and the DOE have also developed a system so that Educational Advocates can be assigned to children with behavioral

health and special needs to assist in insuring that the child/youth is provided with the assistance needed.

7. *What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescent receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.*

The cut-off age in RI for receiving mental health services in the child/adolescent system is age eighteen. At that time, a youth is considered to be able to sign for him/herself. For youth in placement, DCYF provides youth development services and supports to help them transition to adulthood successfully. For youth in out of home care, transition planning starts six months after a youth turns 16 and is updated every six months. The Youth Development Team provides a variety of services through the Consolidated Youth Services Program.

Some DCYF youth with SED in placement due to severity of SED, medical, other complications or co-occurring conditions requiring a higher level of residential care may remain open to DCYF with services until they are transitioned to the adult system or to their 21st birthday. Efforts are made to transfer the youth as smoothly and efficiently as possible to the adult system while meeting the needs of the youth.

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant ([Title XIX, Part B, Subpart II, Sec.1922 \(c\)](#)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at <http://www.samhsa.gov/women-children-families>: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges*.

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Pregnant Women and Women with Dependent Children

1. *The implementing regulation **requires** the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.*

Contracts and regulations: BHDDH includes in its regulations and contracts that programs prioritize pregnant women for admissions to treatment and that agencies include this priority in admissions policies. Through contract monitoring and regular participation in planning with the Drug and Alcohol Treatment Association, particularly in the Neo-natal Abstinence Syndrome Committee, providers are reminded of the policies and of the requirement that they contact BHDDH if they are unable to place pregnant women within 48 hours. The MCOs supply quarterly reports that include performance measures for healthy births. BHDDH will work with Medicaid to integrate our collective goals.

Public Outreach/Awareness: Information about Pregnant women as a priority population for admission to licensed substance abuse treatment programs is integrated into BHDDH funded trainings, including trainings for Mental Health Health Homes and Opioid Health Home Programs. BHDDH instructs all licensed programs to publish priority populations for admission to onsite as well as on the various website. BHDDH's website also includes this information.

Targeted Information: Flyers have been and will be sent to the Department of Human Services including WIC Nutrition, and Home Visiting Programs, Department of Health, DCYF, Community Action Programs, Federally Qualified Health Centers, and hospitals.

Policies: All agencies receiving public and federal funding for substance abuse treatment must have policies around how they will publicize and admit priority populations.

Interventions: BHDDH reviews agencies' adherence to their policies during licensing and agency audits. The Division Administrator of BHDDH meets with each agency manager during the bi-annual licensing audit to complete the Substance Abuse prevention and treatment Block Grant monitoring check list tool to ensure compliance and adjust and educate for management turnover.

The state Peer Review committee also monitors this issue during agency reviews, and reports any negative outcomes to the Division of Behavioral Healthcare.

Sanctions: Corrective Plans of Action will be mandatory for any licensed agency that is not in compliance with publicizing that pregnant women are priority for admission.

Collaboration: BHDDH strategizes with hospitals and the Drug and alcohol Treatment Association around engaging pregnant women in opioid treatment. BHDDH staff members are also on the Governor's Overdose task Force sub-committee on NAS that addresses many issues including issues that arise with pregnant females needing access to treatment including but not

limited to MAT services. BHDDH also collaborates with EOHHS/Medicaid authority on pregnant woman and co-occurring issues.

2. *Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.*

A BHDDH staff member collects a weekly waiting list for all clients awaiting residential/detox treatment by priority. The staff member is also the key contact for any issues that arise concerning priority populations. For residential treatment, if the beds are full, BHDDH has two allocated “respite” beds that provide interim services for high risk clients awaiting placement. BHDDH also has step down services to be used as clinically appropriate.

There is sufficient capacity in the RI outpatient services system. BHDDH has never received a complaint about lack of access to services and continues to review during licensing audits.

Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.

The above listed waiting list also has an area to describe what interim services are being provided while a client is awaiting placement. If left incomplete the BHDDH staff member does a follow up to ensure interim services are being implemented.

3. *Discuss who within your state is responsible for monitoring the requirements in 1-3.*

Linda Mahoney, Administrator for Behavioral Health Services and Laura Mahan is responsible for the residential waiting list.

4. *How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)*

SStarbirth (Residential) and Project Link (Out-patient) are the two treatment facilities that service both women and their infants. Many other programs service pregnant women but not specific with infants.

- a. *How many of the programs offer medication assisted treatment for the pregnant women in their care?*

All the Licensed SA residential facilities in RI offer MAT treatment that is coordinated with local OTP programing. Women and Infant’s hospital, a RI hospital serving all of New England also has an arrangements with the OTP Health Home program to help women needing Methadone that have been recently seen in their ER.

- b. *Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?*

Rhode Island being the size that it is allows for access to all treatment sites. Women with difficult with transportation are supported through transportation programs available through contracts with the MCO's and care coordination through Health Homes.

5. *How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)*

SStarbirth (Residential) and Project Link (Out-patient) are the two treatment facilities that service both women and their dependent children. Licensed Behavioral healthcare organizations are also required to support women and their pregnant children.

- a. *How many of the programs offer medication assisted treatment for the pregnant women in their care?*

Beyond the two listed pregnant women specific programs listed above RI also has 5 MAT clinic's with 12 locations throughout RI. Pregnant women are also being treated with Subutex by private physicians who have acquired the waiver to prescribe buprenorphine and have made arraignments with local hospitals for admissions.

- b. *Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?
Please indicate areas of technical assistance needed related to this section.*

There are no geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

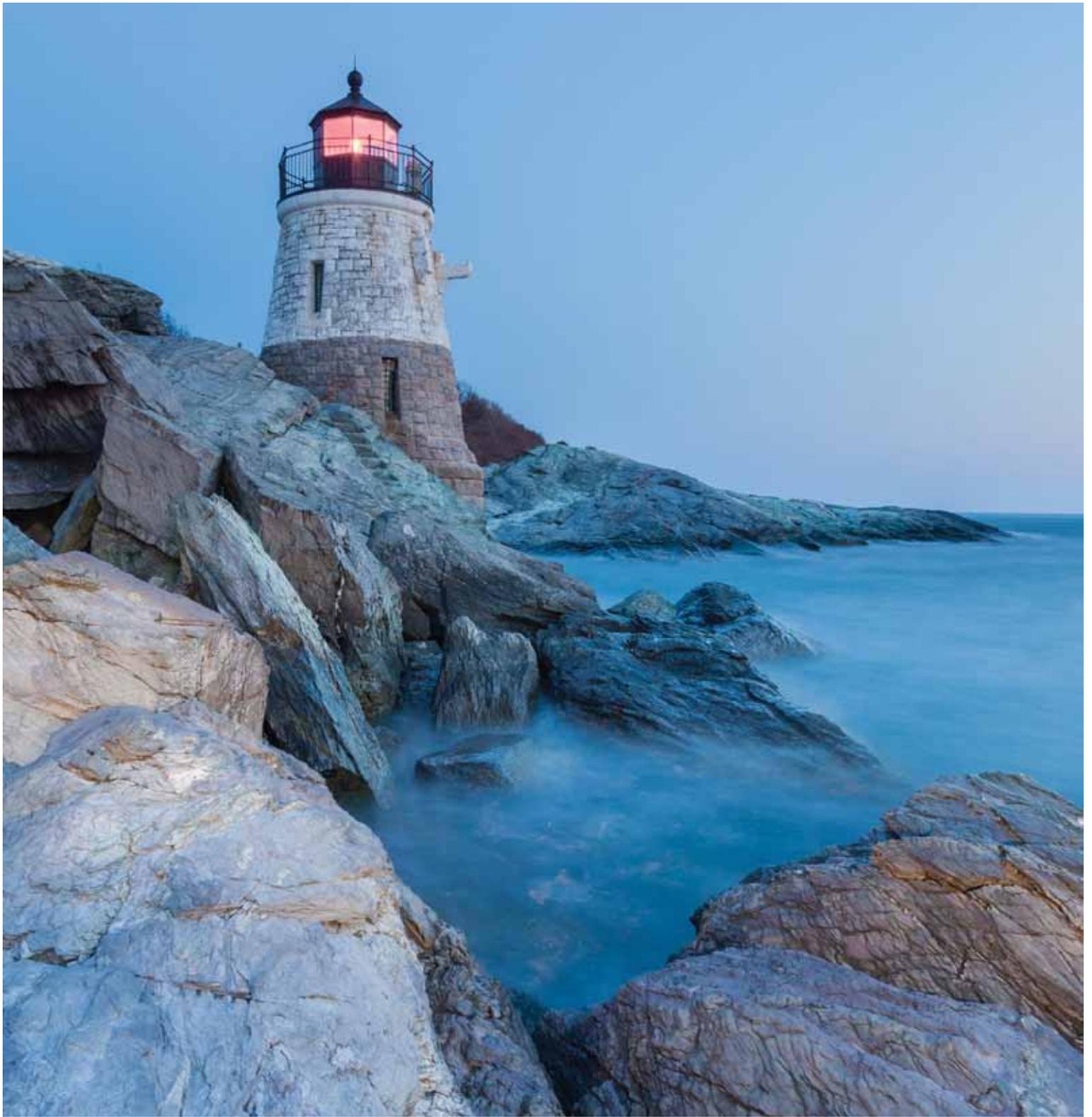
1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).⁹⁶

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

⁹⁶ http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:



PREVENTING VIOLENCE AND INJURIES IN RHODE ISLAND

2011–2016 Rhode Island Strategic Plan



PREVENTING VIOLENCE AND INJURIES A PLAN FOR THE STATE 2011–2016

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July 31, 2013

To Our Partners in Injury Prevention:

I am pleased to present the Rhode Island Violence and Injury Prevention Plan, developed by our community partners and the Violence and Injury Prevention Program. Population-based data and findings from the injury research community were used to craft the recommendations in this plan.

Injury is a public health epidemic. It is the leading cause of death and disability for Rhode Islanders ages 1 to 44. It is a problem that no one agency or group can solve alone. We encourage you to use this plan to direct your efforts to prevent injuries, and to collaborate with us in that process. Working together, we can reduce injuries and deaths by educating adults and children about prevention, promoting proven policies, providing safety devices to families in need, and searching for effective solutions to problems.

Thank you for partnering with HEALTH to make Rhode Island a safer and healthier state. Please contact Beatriz Perez at 401-222-7627 if you have any questions or comments regarding the Violence and Injury Prevention Program.

Sincerely,

A handwritten signature in blue ink that reads "Michael Fine".

Michael Fine, MD
Director of Health, Rhode Island Department of Health

HELPFUL DEFINITIONS

Injury: Damage or harm to the body resulting in impairment or destruction of health.

Prevention: A systematic process that promotes safe and healthy environments and behaviors, reducing the likelihood or frequency of an injury occurring.

Injuries are grouped into two categories:

Unintentional injury: An injury that is judged to have occurred without anyone intending that harm be done.

Intentional injury: An injury that is judged to have been purposely inflicted either by the self or another.



INTRODUCTION

Injury is the leading cause of death for people ages 1–44 in Rhode Island and in the United States. Each year, more than 600 injury-related deaths occur in Rhode Island and over 180,000 injury-related deaths occur nationwide.¹ Unintentional motor vehicle crashes, unintentional falls, suicides, and unintentional drug overdoses are some of the tragedies that affect everyone, regardless of gender, race, or economic status. In addition to the toll these tragedies take on both the lives and health of people and their families, there is also a significant economic and societal burden. Nationally, over \$400 billion is spent on medical expenses and lost productivity due to injuries every year.² While many people accept injury-related accidents as “part of life,” most injuries are predictable and preventable.³

The Rhode Island Department of Health (HEALTH) has made violence and injury prevention a statewide priority over the past decade. In 2002, HEALTH received a grant from the US Centers for Disease Control and Prevention (CDC) to assess and plan for injury prevention in the state. This investment supported the establishment of the Rhode Island Violence and Injury Prevention Program (VIIP). The VIIP sits within the Division of Community, Family Health, and Equity at HEALTH. The VIIP uses a health equity approach based on the *Health Equity Pyramid*. This approach was adapted from a framework developed by CDC Director Thomas Frieden, MD, MPH that emphasizes the importance of interventions with the most potential for improving population health.⁴ The VIIP focuses resources on interventions that inform policy and enhance social support systems, systems of care, and environmental change. (See Appendix I for the Equity Pyramid.)

The charge of the VIIP is to identify injury prevention priorities and to support the implementation and evaluation of statewide interventions based on population-based recommendations. In 2005, the program published the first comprehensive Rhode Island Injury Prevention Plan (available at www.health.ri.gov/publications/plans/2005InjuryPrevention.pdf). The 2011-2016 plan is an update of the previous plan and reflects the current scope of violence and injury prevention in the state.



Rhode Island violence and injury prevention activities are guided by the Injury Community Planning Group (ICPG) Steering Committee. (See Appendix II for the ICPG structure.) Michael Mello, MD, MPH, the Director of the Injury Prevention Center at Rhode Island Hospital, chairs this professional-level steering committee. The ICPG members include the chairs of four subcommittees that address violence and injury priority areas selected for program planning and implementation. The subcommittees are the:

- Drug Overdose Prevention and Rescue Subcommittee
- Falls Injury Prevention Subcommittee
- Motor Vehicle Injury Prevention Subcommittee, officially named the Rhode Island Traffic Safety Coalition
- Suicide Prevention Subcommittee

Subcommittees convene regularly and represent diverse stakeholders from government agencies, community-based organizations, private entities, and individuals affected by injury.

The ICPG and its subcommittees used a data-driven, collaborative process to develop the plan content. A consensus decision-making approach was used to determine measurable goals and objectives, identify priority populations, select evidence-based interventions, and develop recommendations. The following criteria informed the selection of the violence and injury priority areas:

- High rates of emergency department visits, hospital discharges, and/or deaths
- Capacity for cooperation and coordination among ongoing injury prevention efforts
- Availability of cost-effective interventions
- Supportive political climate
- Potential for involvement and accountability of multidisciplinary partners
- Capability for measurable progress over a five-year period (2011-2016)

The planning process resulted in a comprehensive strategy for the prevention of death and injury by unintentional drug overdoses, unintentional falls, unintentional motor vehicle crashes, and suicides/attempts in Rhode Island.

The goals, objectives, and recommendations listed in this plan provide a framework to guide injury prevention programming for the VIPP and for partner organizations working to reduce the burden of injury in Rhode Island. For example, local businesses, community organizations, advocacy groups, planners, decision makers, and researchers can consult the plan to make decisions regarding collaboration, policy, program planning, and research. The plan also provides a clear vision for future direction and growth of the VIPP and ICPG partners.

Nationally, over \$400 billion is spent on medical expenses and lost productivity due to injuries every year. While many people accept injury-related accidents as “part of life,” most injuries are predictable and preventable.

THE BURDEN OF INJURY IN RHODE ISLAND

Reliable estimates of the burden of injuries are essential for statewide program planning. Rhode Island’s population-based injury surveillance system is built around three core data sets: 1) Rhode Island Vital Records Death Certificate Data, 2) Rhode Island Hospital Discharge Data, and 3) Rhode Island Emergency Department Data. These three databases were used to select the violence and injury priority areas and the priority populations discussed in this plan. All rates presented in this plan are average rates per 100,000 Rhode Islanders, based on the 2010 US Census. (See Appendix III for a description of the data sets used in this report.)

From 2008-2010, unintentional injuries were the fourth-leading cause of death for Rhode Islanders of all ages and the leading cause of death for Rhode Islanders ages 1 through 44 (Figure 1). On average, 600 Rhode Islanders died each year due to intentional and unintentional injury-related causes.¹ Only heart disease, cancer (malignant neoplasms), and chronic lower respiratory diseases killed more Rhode Islanders than injury-related causes (Figure 1).

FIGURE 1
10 Leading Causes of Death by Age Group, Rhode Island, 2008-2010

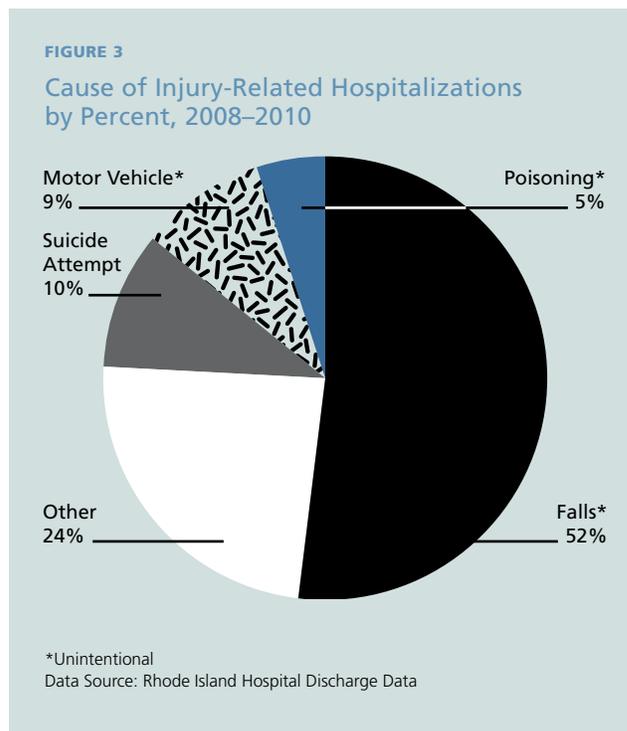
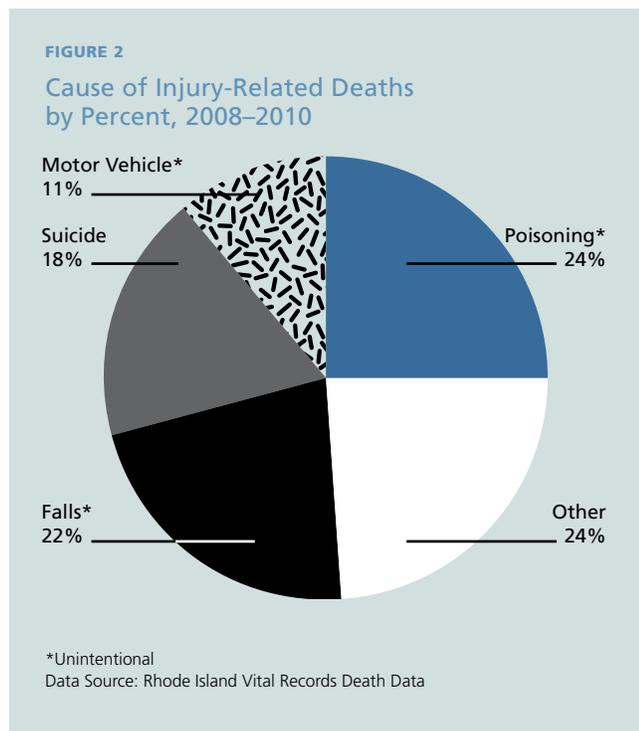
Rank	Age Groups										All Ages
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Short Gestation 47	Unintentional Injury ---	Unintentional Injury ---	Unintentional Injury ---	Unintentional Injury 106	Unintentional Injury 126	Unintentional Injury 179	Malignant Neoplasms 557	Malignant Neoplasms 1,150	Heart Disease 6,369	Heart Disease 7,390
2	Congenital Anomalies 32	Congenital Anomalies ---	Homicide ---	Malignant Neoplasms ---	Suicide 33	Suicide 47	Malignant Neoplasms 113	Heart Disease 303	Heart Disease 599	Malignant Neoplasms 4,840	Malignant Neoplasms 6,713
3	Placenta Cord Membranes 25	Heart Disease ---	Congenital Anomalies ---	Suicide ---	Homicide 29	Malignant Neoplasms 30	Heart Disease 88	Unintentional Injury 253	Unintentional Injury 134	Chronic Low Respiratory Disease 1,353	Chronic Low Respiratory Disease 1,496
4	SIDS 23	Malignant Neoplasms ---	Aortic Aneurism ---	Benign Neoplasm ---	Malignant Neoplasms 15	Homicide 25	Suicide 87	Liver Disease 101	Chronic Low Respiratory Disease 105	Cerebrovascular 1,156	Unintentional Injury 1,383
5	Bacterial Sepsis 11	Chronic Low Respiratory Disease ---	Benign Neoplasm ---	Influenza + Pneumonia ---	Heart Disease 10	Heart Disease 11	Cerebrovascular 21	Suicide 100	Liver Disease 105	Alzheimer's Disease 1,001	Cerebrovascular 1,322
6	Maternal Pregnancy Comp ---	Homicide ---	Chronic Low Respiratory Disease ---	Chronic Low Respiratory Disease ---	Congenital Anomalies ---	Congenital Anomalies ---	HIV 18	Cerebrovascular 53	Diabetes Mellitus 90	Influenza + Pneumonia 612	Alzheimer's Disease 1,018
7	Neonatal Hemorrhage ---		Liver Disease ---	Septicemia ---	Cerebrovascular ---	Diabetes Mellitus ---	Liver Disease 14	HIV 40	Cerebrovascular 85	Unintentional Injury 565	Influenza + Pneumonia 676
8	Septicemia ---		Malignant Neoplasms ---		Influenza + Pneumonia ---	Complicated Pregnancy ---	Influenza + Pneumonia 11	Diabetes Mellitus 37	Suicide 57	Nephritis 498	Diabetes Mellitus 619
9	Circulatory System Disease ---				Four Tied ---	Five Tied ---	Homicide 10	Chronic Low Respiratory Disease 28	Septicemia 50	Diabetes Mellitus 480	Nephritis 552
10	Other Maternal Conditions ---				Four Tied ---	Five Tied ---	Diabetes Mellitus ---	Septicemia 25	Viral Hepatitis 37	Septicemia 357	Septicemia 441

The “...” symbol means that counts of less than 10 have been suppressed. Shaded areas represent an injury- or violence-related cause of death. Data Source: Centers for Disease Control and Prevention, WISQARS™ (Web-based Injury Statistics Query and Reporting System)

The financial cost of injury-related fatalities in Rhode Island has had a significant economic impact. Each year, deaths due to unintentional poisoning,* unintentional falls, unintentional motor vehicle crashes, and suicides cost over seven million dollars in the state.⁵ This estimate is based on medical costs and does not include costs of loss of productivity, the emotional burden resulting from the loss of a loved one, or the personal and economic impact of severe disability.

In addition to injury-related deaths, non-fatal injuries also contribute a significant economic burden. Non-fatal injuries are consistently among the leading causes of hospital admissions in Rhode Island.⁶ These injuries can result in a range of outcomes, including temporary pain and inconvenience, chronic pain, or permanent disability. Each year, about 6,000 Rhode Islanders are hospitalized due to injury-related causes.⁶ In Rhode Island, the average annual cost of hospitalizations due to unintentional drug overdoses, unintentional falls, unintentional motor vehicle crashes, and suicides attempts† is estimated at \$110 million.⁵

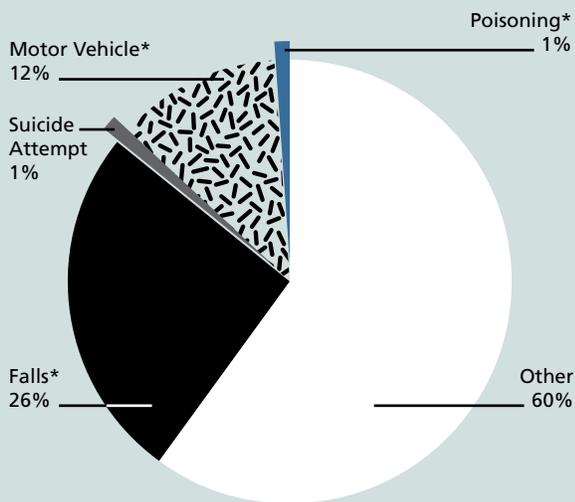
The Violence and Injury Prevention Program (VIPP), in collaboration with the Injury Community Planning Group (ICPG), identified the four violence and injury priority areas based on 2006-2010 state-level injury data. From 2008-2010, the following four types of injury accounted for the greatest proportion of injury-related deaths in the state: unintentional poisoning (24%), unintentional falls (22%), suicide (18%), and unintentional motor vehicle crashes (11%) (Figure 2). Hospital discharge data signify cases of injury that are severe enough to require the patient’s admittance to the hospital. From 2008-2010, unintentional falls accounted for 52 percent of injury-related hospitalizations, with suicide attempts and motor vehicle injuries at 10 percent and 9 percent, respectively (Figure 3).



*The VIPP uses a death record, hospital discharge, or emergency department visit due to unintentional poisoning as a marker for an unintentional drug overdose.

† The VIPP uses a hospital discharge or emergency department visit due to self harm as a marker for a suicide attempt.

FIGURE 4
Cause of Injury-Related Emergency Department Visits, 2008–2010



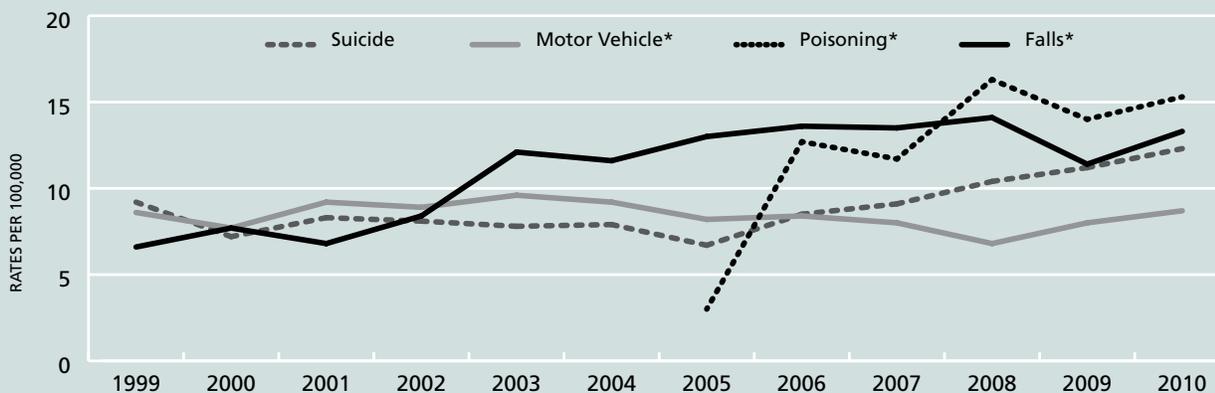
*Unintentional
Data Source: Rhode Island Emergency Department Data

Figure 4 displays 2008-2010 injury-related emergency department visits where the patient was treated and discharged.† These cases of injury are typically much less severe than injuries that result in a hospital admission. Although unintentional falls and unintentional motor vehicle crashes made up 26 percent and 12 percent of injury-related emergency department visits respectively, the remaining 60 percent of injuries fell into the ‘other’ injury category. The most common injury-related emergency department visits in the ‘other’ category resulted from being struck by an object, overexertion, a cut or pierce, a fire or burn, environmental factors, and unspecified causes.

Over the past decade, the burden of death from unintentional falls, unintentional motor vehicle crashes, and suicides in Rhode Island has remained relatively stable (Figure 5). The annual death rate has ranged from 7 to 14 deaths per 100,000 population for unintentional falls, 7 to 10 deaths per 100,000 population for unintentional motor vehicle crashes, and 7 to 12 deaths per 100,000 population for suicides.

In 2008, unintentional poisoning became the leading cause of injury-related death in Rhode Island. Unintentional poisoning is a new public health epidemic that has grown at an unprecedented rate. Rhode Island jumped from less than 1 unintentional poisoning death per 100,000 population in 1999 to over 15 unintentional poisoning deaths per 100,000 population in 2010 (Figure 5). The majority of unintentional poisoning deaths involve prescription opioid painkillers. Rhode Island data reflect a national phenomenon of an increase in unintentional drug overdose death rates driven largely by prescription opioid painkillers.⁷

FIGURE 5
Trends in Injury-Related Death Rates, Rhode Island, 1999–2010



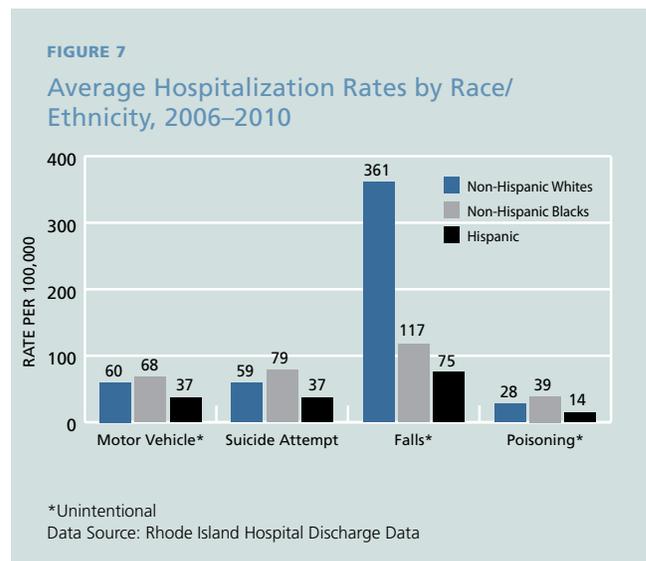
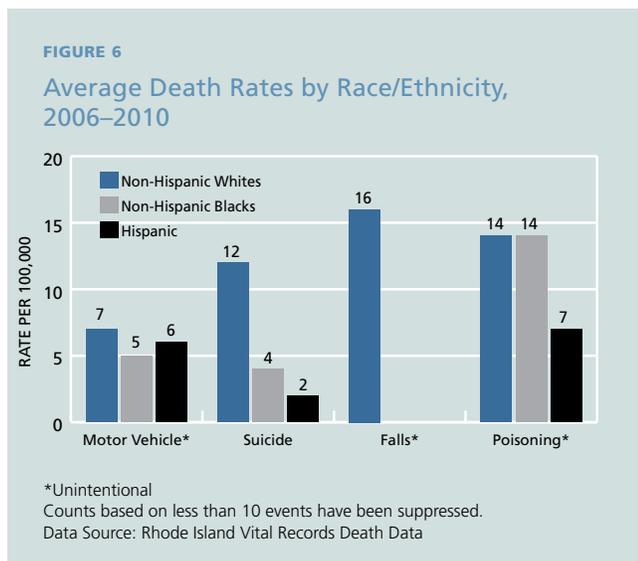
*Unintentional
Data Source: Centers for Disease Control and Prevention. WISQARS™ (Web-based Injury Statistics Query and Reporting System).

† Emergency department visits do not include cases where the patient was seen in the emergency room and then admitted to the hospital. Emergency department data and hospital discharge data are mutually exclusive databases.

Race/Ethnicity:

Figures 6 and 7 show the burden of injuries by race/ethnicity in Rhode Island. Non-Hispanic whites, non-Hispanic blacks, and Hispanics had equal rates of motor vehicle-related fatalities during 2006-2010 (Figure 6). The rate for death due to unintentional poisoning was similar for non-Hispanic whites and non-Hispanic blacks, while the Hispanic rate was lower (Figure 6). Non-Hispanic whites were more likely to die from a suicide or an unintentional fall than both non-Hispanic blacks and Hispanics (Figure 6).

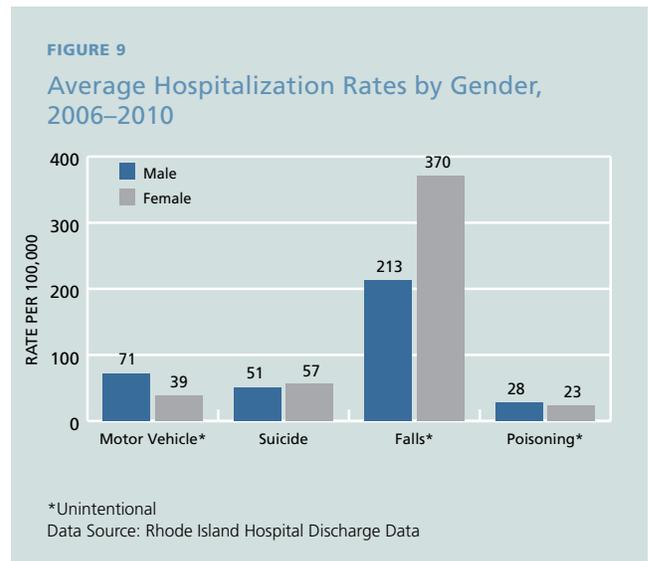
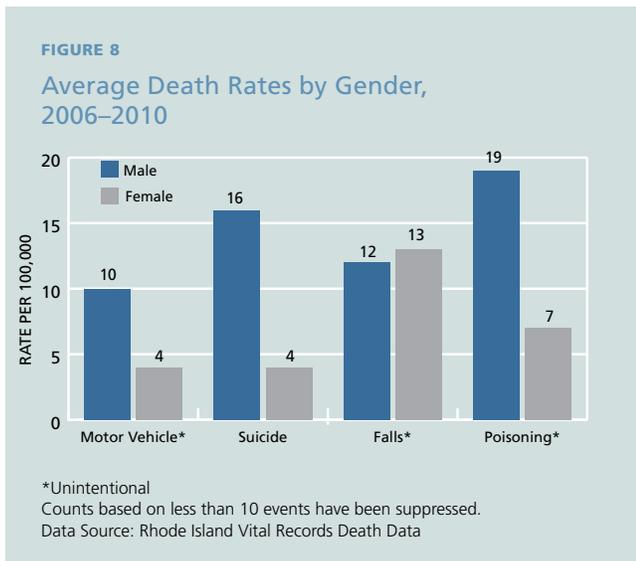
From 2006-2010, the hospitalization rates for unintentional poisoning, unintentional motor vehicle injuries, and suicide attempts were similar for non-Hispanic blacks and non-Hispanic whites, and lower for Hispanics (Figure 7). Non-Hispanic whites were much more likely to be hospitalized for an unintentional fall than non-Hispanic blacks and Hispanics (Figure 7).



Gender:

Figures 8 and 9 demonstrate the burden of injuries by gender in Rhode Island. During 2006-2010, males were more likely to die from an unintentional motor vehicle crash, a suicide, and an unintentional poisoning than females; however, the death rate for unintentional falls was relatively similar for the two genders (Figure 8).

From 2006-2010, females were more likely to be hospitalized for an unintentional fall-related injury than males. Males were more likely to be hospitalized for an unintentional motor vehicle-related injury. There were no differences in the hospitalization rates for suicide attempts and unintentional poisoning between the two genders (Figure 9).

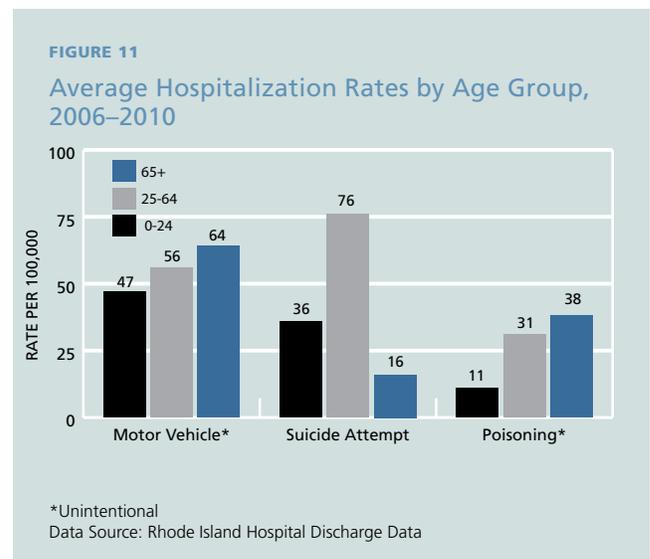
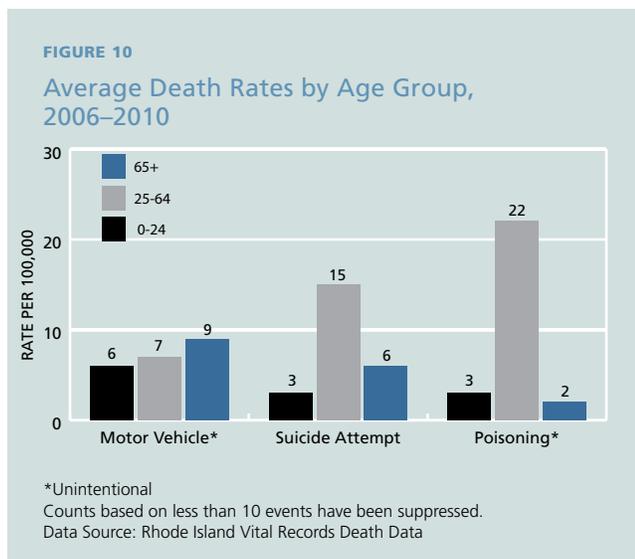


Age:

Figures 10 and 11 show the burden of injuries by age group in Rhode Island. The death and hospitalization rates for unintentional falls are not included because the target age group (at national and state level) for falls prevention is adults age 65 and older.

During 2006-2010, adults age 25 through 64 were more likely to die by suicide or poisoning, in comparison to both younger and older age groups (Figures 10). Adults age 25 through 64 were also most likely to be hospitalized for a suicide attempt (Figure 11). Risk of a hospitalization due to an unintentional poisoning increased with age (Figure 11).

According to Figures 10 and 11, risk of a death or hospitalization by motor vehicle crash increased with age; however, the broad age group distribution shown here does not demonstrate the injury-related burden of deaths and hospitalizations for smaller age groups. For example, from 2006-2010, youth age 15 through 24 were most at risk for motor vehicle-related death and hospitalizations. The burden of injury by age group is more detailed in the specific priority area chapters.



The objective of the burden of injury section of this report is to provide timely and relevant information on unintentional poisoning, unintentional falls, unintentional motor vehicle crashes, and suicide attempts/suicides. The following sections discuss each priority area in greater depth.



DRUG OVERDOSE PREVENTION AND RESCUE

Unintentional Drug Overdose:

A drug overdose is considered a poisoning. This type of poisoning can occur by eating, drinking, breathing, injecting, or absorbing a substance(s), such as a prescription medication or a street drug that is harmful to the body.

Burden of Injury from Unintentional Drug Overdose:

Rhode Island ranks seventh in the nation for its drug overdose death rate.⁸ Rhode Island data reflect a national epidemic of drug overdose death rates driven largely by prescription opioid painkillers.⁷ Drug-related deaths claimed the lives of 193 Rhode Islanders in 2008; this equals almost four people each week. The most common drugs involved in the deaths were prescription opioids, such as oxycodone.⁷

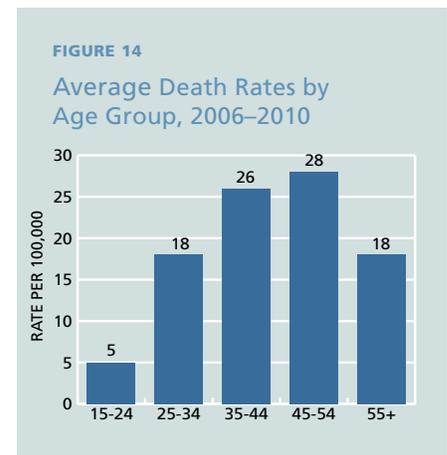
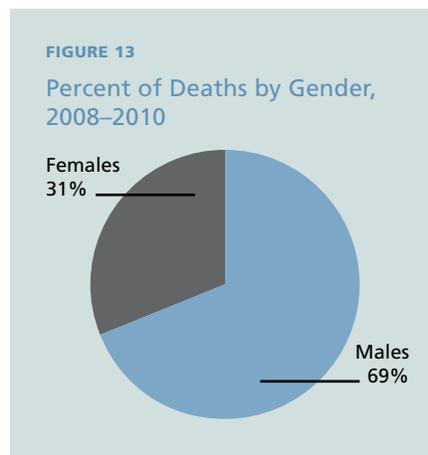
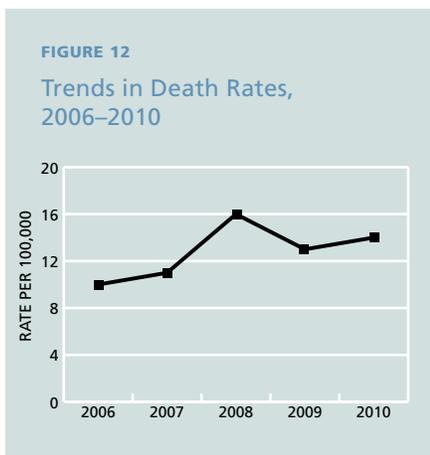
The Violence and Injury Prevention Program (VIIPP) uses a death record, an inpatient hospital admission, or an emergency department visit coded as an unintentional poisoning as a marker for an unintentional drug overdose (Figures 12-17). Unintentional poisoning death rates increased from 10 to 14 per 100,000 population between 2006 and 2010 (Figure 12). Unintentional poisoning is now the leading cause of unintentional injury-related death in Rhode Island.¹

During 2008-2010, men were more likely to die from an unintentional poisoning than women: 69% versus 31%, respectively (Figure 13). Unintentional poisoning affects a broad age range, with adults age 35 through 54 at the highest risk (Figure 14).

Males and females were equally likely to be hospitalized for a non-fatal, unintentional poisoning: 51% versus 49%, respectively (Figure 15). The risk of being hospitalized for an unintentional poisoning-related injury increased with age through age 54 and then dropped slightly for adults age 55 and older (Figure 16). Over a three-year period (2008 to 2010), there were 879 hospitalizations and 4,418 emergency department (ED) visits due to unintentional poisoning-related injuries in Rhode Island (Figure 17).

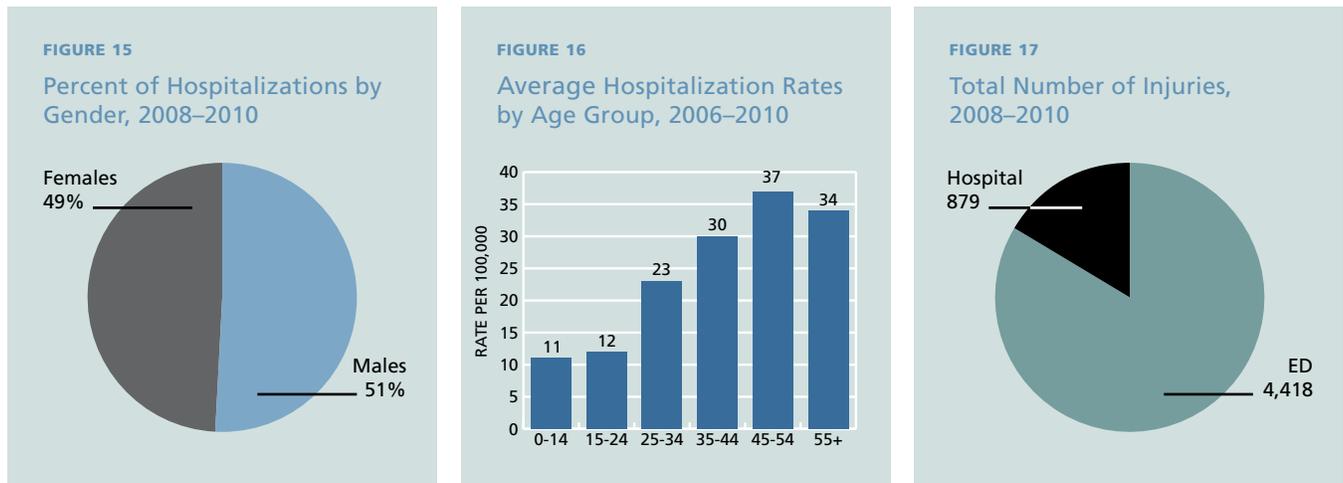
From 2006-2010, death and hospitalization rates for unintentional poisoning were similar for non-Hispanic whites and non-Hispanic blacks, while rates were lower for Hispanics (data not shown in this chapter).

Rhode Island Fatal Unintentional Poisonings*



*Rates based on less than 10 events have been suppressed.
Data Source: Rhode Island Vital Records Death Data

Rhode Island Non-fatal Unintentional Poisonings



Data Sources: Rhode Island Hospital Discharge Data, Rhode Island Emergency Department Data

Goal: Prevent death from unintentional drug overdose.

Objectives:

1. Decrease or maintain the 2009 rate of deaths due to unintentional poisonings in Rhode Island at 13 per 100,000 or less through 2016.

Priority Populations: The general population
 Individuals age 15-54 who are using opioids non-medically
 Any individual prescribed opioids

Risk Factors:

- Enrolled in Medicaid⁹
- Prescribed high daily doses of opioids^{10,11}
- Living in a rural area¹²
- Misuse of multiple drugs and/or alcohol^{13,14,15,16}
- Mental illness and a history of substance abuse¹⁷

Evidence-based strategies:

To date, interventions to prevent prescription opioid overdose deaths have not been systematically evaluated. The Centers for Disease Control and Prevention (CDC) recently released several promising recommendations for prevention, including the establishment and use of Prescription Monitoring Programs (PMPs).¹⁸ A PMP is a state database that tracks the prescribing and dispensing of controlled substances to patients. The VIPP works to increase appropriate usage and access to the Rhode Island PMP by physicians, pharmacists, and other prescribers.

Another promising initiative in Rhode Island is a pilot drug overdose prevention research study, Preventing Overdose and Naloxone Intervention (PONI). Naloxone is an opioid antagonist effective in reversing an opioid drug overdose. It can be



administered by a layperson either intravenously or nasally. PONI educates high-risk populations on drug overdose risk and prevention, trains them to administer naloxone, and distributes naloxone following training. Of the 120 participants in the 2011 study, 10 returned for a follow-up with the PONI staff, and 5 of these participants reported successfully administering intramuscular naloxone to reverse an opioid overdose.¹⁹ Preliminary results demonstrate a potential to greatly reduce overdose-associated deaths in Rhode Island if the PONI program is expanded.¹⁹

The CDC also recommends the following promising strategies for prevention: patient review and restriction programs, increasing of healthcare provider accountability, laws to prevent prescription drug abuse and diversion, and better access to substance abuse treatment.¹⁸ The VIPP will support statewide partners in implementing and evaluating promising CDC-endorsed strategies. The Drug Overdose Prevention and Rescue Subcommittee of the Injury Community Planning Group also recommends the following strategies for statewide implementation. (See Appendix IV for the subcommittee membership list.)

Recommendation 1: Establish statewide overdose surveillance mechanisms.

- 1.1: Create a system for interdisciplinary review of overdose cases for surveillance and prevention planning in partnership with the Office of State Medical Examiners.
- 1.2: Develop a core data set with overdose-relevant data and a standardized report.
- 1.3: Determine evidence-based working definitions of “doctor shopping,” “questionable medication-use behavior,” and “questionable prescribing practices.”
- 1.4: Create a state database that captures the amount of opiates prescribed (number and per capita) and the demographics they are prescribed to.
- 1.5: Develop a state database that tracks the number of people that enter medication-assisted treatment (methadone, buprenorphine, depot-naltrexone) and the length of treatment.
- 1.6: Develop a data collection system that tracks heroin use in Rhode Island.

Recommendation 2: Increase usage and effectiveness of the Prescription Monitoring Program (PMP).

- 2.1: Increase the number of providers registered for the PMP.
- 2.2: Increase the number of providers who use the PMP.

- 2.3: Link the PMP to electronic health records systems.
- 2.4: Develop educational materials to train providers on addiction resources and overdose prevention strategies to address information discovered in the PMP.
- 2.5: Require mandatory patient history checks in the PMP before prescribing a controlled medication for all new patients, when a patient rotates from one opioid to another, and/or when a patient is prescribed a higher dose (> 50 milligrams morphine unit per day).
- 2.6: Expand the PMP to capture prescribing information from other states.
- 2.7: Expand the PMP to capture benzodiazepine (“benzo”) prescribing information.

Recommendation 3: Increase access to naloxone training and distribution programs.

- 3.1: Implement naloxone training for the Emergency Medical Services (EMS) workforce statewide.
- 3.2: Expand intranasal naloxone use by EMS.
- 3.3: Implement naloxone training for the law enforcement workforce statewide and outfit police officers with naloxone.
- 3.4: Expand the Collaborative Practice Agreement pilot project with Walgreens pharmacy and other pharmacies to increase access to naloxone.
- 3.5: Implement naloxone training and distribution programs for inmates upon release.
- 3.6: Implement naloxone training and distribution programs at substance abuse treatment programs upon participant release.
- 3.7: Increase coverage of naloxone by RIte Care (public insurance) and other insurance providers.
- 3.8: Implement naloxone training and distribution programs through Employee Assistance Programs and the Rhode Island Interlocal Trust.
- 3.9: Implement naloxone training and distribution programs through community-based organizations and at recovery community centers.

Recommendation 4: Increase licensed healthcare worker and institutional responsibility.

- 4.1: Encourage conversations among patients, parents/guardians, providers, and pharmacists about prescription drug risks and safety, drug treatment options, and naloxone prescription.
- 4.2: Notify prescribers and dispensers when their patients die from a prescription drug overdose, in partnership with the Office of State Medical Examiners.
- 4.3: Increase opportunities for and implement mandatory continuing education for licensed healthcare workers.
- 4.4: Require prescribers to provide risk information, drug overdose prevention resources, and/or naloxone prescriptions to patients when writing opioid prescriptions.
- 4.5: Require pharmacies to provide written information on overdose risk and naloxone education when filling opioid prescriptions.
- 4.6: Support efforts to implement limits on the opioid day supply to patients at emergency department and urgent care clinics (e.g. three-day supply limits).

Recommendation 5: Implement and expand disposal units throughout the state.

- 5.1: Pilot and evaluate prescription drug disposal programs in partnership with police stations, pharmacies, schools, churches, and other organizations.

Recommendation 6: Support prevention policies that work.

- 6.1: Increase awareness of the Good Samaritan Law[§] among the general public, law enforcement officers, healthcare workers, prison system employees, and Emergency Medical Services staff, and support its reimplementation in 2015.
- 6.2: Support policies that include Schedule IV and Schedule V drugs in the Prescription Monitoring Program coverage.
- 6.3: Review pharmacy dispensing laws and/or regulations and propose an exception to permit naloxone prescribing and dispensing (for example, by granting permission to certified sites, such as treatment centers, prisons, and community-based organizations).

Recommendation 7: Increase general public awareness of drug overdose as a preventable public health problem.

- 7.1: Educate the public on overdose risks, especially changes in tolerance and the dangers of mixing multiple drugs and/or alcohol.
- 7.2: Educate the public on the signs and symptoms of a drug overdose.
- 7.3: Educate the public on the importance of protecting/locking up their prescription drugs and disposing of unused opiates and benzodiazepines ("benzos").
- 7.4: Educate the public on the effectiveness of treatment.
- 7.5: Educate parents and students on recommendations 7.1-7.4 above.
- 7.6: Develop a comprehensive education and outreach strategy, including school programming and television, print, radio, and social media campaigns.

Recommendation 8: Support and affirm people at risk for drug overdose.

- 8.1: Normalize conversations between a provider and patient about prescription drug risk.
- 8.2: Normalize naloxone availability in the home.
- 8.3: Normalize calling 911 in the case of a drug overdose without fear of consequences.
- 8.4: Decrease stigma associated with drug addiction.
- 8.5: Increase the number of participants in Stanford University's Chronic Pain Self-Management Program or comparable chronic pain self-management programs.

Recommendation 9: Increase access to substance abuse treatment.

- 9.1: Identify, support, and promote substance abuse programs.
- 9.2: Support recovery efforts, including the expansion of recovery support service providers.
- 9.3: Increase the number of physicians that prescribe buprenorphine by increasing access to the eight-hour training and encouraging medical schools to require buprenorphine prescribing training of all graduates.

Recommendation 10: Build state capacity to implement drug overdose prevention and rescue programs.

- 10.1: Secure funding to hire a drug overdose and rescue project coordinator.
- 10.2: Secure funding to implement plan recommendations.
- 10.3: Establish partnerships with agencies and individuals whose work is relevant to drug overdose prevention and rescue to leverage resources.

[§]The Good Samaritan Law gives legal protection to people (lay people and healthcare providers) who give reasonable assistance or call 911 to help those who are injured in an emergency situation.



FALL-RELATED INJURY PREVENTION

Unintentional Fall:

A fall is an event that results in a person coming to rest inadvertently on the ground, floor, or other lower level.

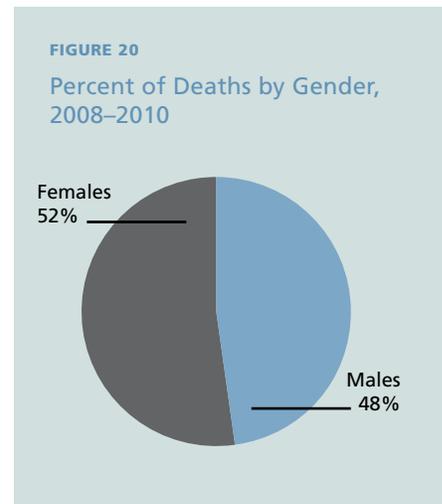
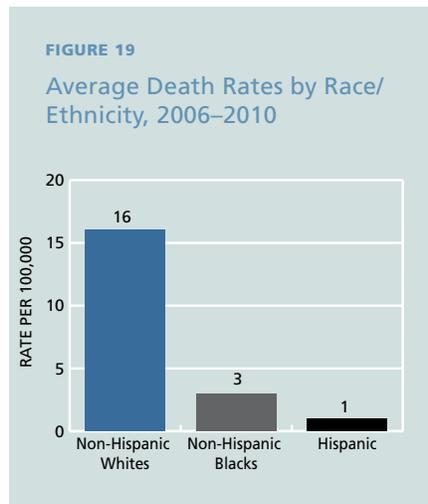
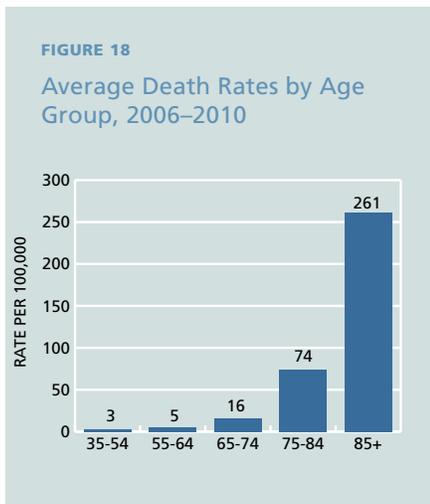
Burden of Injury from Falls:

Unintentional falls are the leading cause of injury-related deaths, hospitalizations, and emergency department visits among Rhode Islanders age 65 and older.²⁰ From 2008-2010, unintentional falls made up over 60% of injury-related deaths for this age group.¹ The risk of dying from an unintentional fall dramatically increases with age: the death rate for adults age 85 years and older was 16 times higher than that for adults ages 65 through 74 and 3.5 times higher than that for adults age 75 through 84 (Figure 18).

Currently, 140,000 Rhode Islanders (14%) are 65 years of age or older. By 2020, 195,000 Rhode Islanders (17.9%) will be age 65 and older.²¹ As the population ages, the impact and cost of fall-related deaths and injuries will increase considerably unless this serious public health issue is addressed.

During 2006-2010, the risk of dying from an unintentional fall was higher for non-Hispanic whites than among non-Hispanic blacks and Hispanics (Figure 19). Of those who died from an unintentional fall, slightly more were women than were men (Figure 20).

Rhode Island Fatal Unintentional Falls*

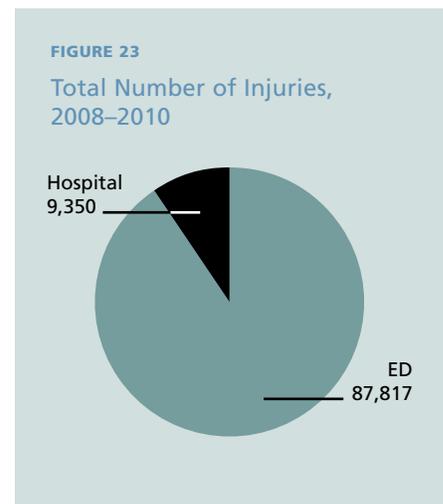
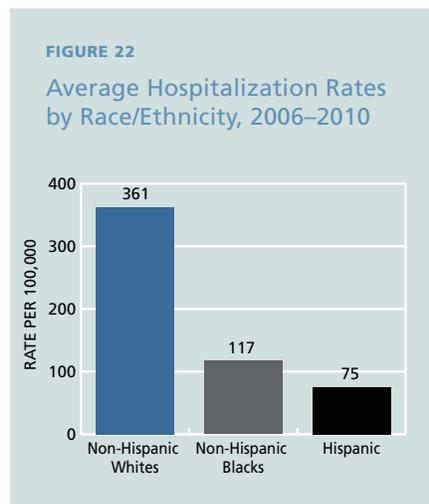
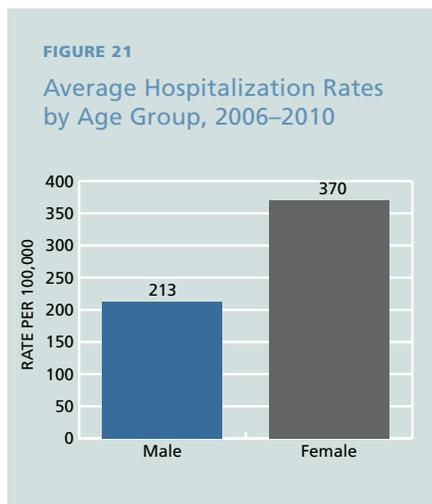


*Rates based on less than 10 events have been suppressed
Data Source: Rhode Island Vital Records Death Data



Unintentional falls are the leading cause of nonfatal injuries in Rhode Island. From 2008-2010, unintentional falls made up over half of injury-related hospitalizations (52%) and 26% of injury-related emergency department visits.²⁰ Women were more likely to be hospitalized for an unintentional fall-related injury than men (Figure 21). Non-Hispanic whites were more likely than non-Hispanic blacks and Hispanics to be hospitalized for an unintentional fall (Figure 22). From 2008-2010, there were 9,350 hospitalizations and 87,817 emergency department visits for unintentional fall-related injuries in Rhode Island (Figure 23).

Rhode Island Nonfatal Unintentional Falls



Data Sources: Rhode Island Hospital Discharge Data, Rhode Island Emergency Department Data

Goal 1: Prevent deaths of older adults caused by falls.*

Goal 2: Prevent injuries to older adults caused by falls.

Objectives:

1. Decrease or maintain the 2009 rate of deaths due to unintentional falls among older adults (65+) in Rhode Island at 71 per 100,000 or less through 2016.
2. Decrease or maintain the 2009 rate of hospitalizations due to unintentional falls among older adults (65+) in Rhode Island at 1,461 per 100,000 or less through 2016.

Priority Populations: Older adults (60+) living in the community
Non-Hispanic white females 65+

Risk Factors:

- Lack of physical activity^{22,23}
- The use of multiple medications (four or more)^{24,25}
- Impaired vision^{22,25}
- Environmental factors (hazardous stairs, poor lighting, uneven surfaces, lack of hand rails, clutter)^{22,24}
- Chronic condition, such as arthritis, Parkinson's disease, or osteoporosis²⁴
- Dementia²⁵
- Postural hypotension (sudden drop in blood pressure when standing up or stretching)²⁴
- Consuming excessive amounts of alcohol²⁷
- Living alone^{28,29}
- History of previous fall^{28,29}
- Fear of falling^{28,29}
- Multiple of the risk factors listed above³⁰

Evidence-based strategies:

The Centers for Disease Control and Prevention (CDC) recommends three categories of interventions for falls prevention: exercise-based, home modification for hazard reduction, and multifaceted (including medical screening for visual impairment and medication review).³¹

Regular exercise is one of the CDC recommendations to reduce the risk of falls.²² Exercise interventions should focus on strength, balance, flexibility, and endurance. Exercising in supervised groups, participating in Tai Chi, and carrying out individually prescribed exercise programs at home are all effective in reducing falls.²² The National Council on Aging has identified several evidence-based exercise programs that have supporting research demonstrating their effectiveness.³² For example, the evidence-based program *A Matter of Balance* is proven to reduce fear of falling and increase physical activity levels in older adults.

*The target population is older adults living independently in their homes (not in nursing homes, independent living facilities, etc.).



Multifaceted interventions that identify a person's risk of falling, and then refer the person for comprehensive treatment to reduce his or her risk, are another recommended strategy.^{33,34} The CDC developed a comprehensive toolkit, *Stopping Elderly Accidents, Deaths, and Injuries* (STEADI), to offer healthcare providers tools and resources to help prevent falls in their older adult patients. The model helps providers identify a patient's risk for falls, assess the scope of a patient's risk, introduce tailored interventions, and offer effective referrals.³⁵

The Violence and Injury Prevention Program (VIPP) supports community partners in the implementation of *A Matter of Balance* and the STEADI toolkit. The Falls Injury Prevention Subcommittee of the Injury Community Planning Group also recommends the following strategies for statewide implementation. (See Appendix V for the subcommittee membership list.)

Recommendation 1: Increase the percent of older adults who exercise on most days of the week.

- 1.1: Promote and provide community-based programs that incorporate falls prevention activities and exercises into programming.
- 1.2: Promote the adoption of home exercise programs.
- 1.3: Increase the number of community health workers trained to implement evidence-based programs such as *A Matter of Balance*, *Tai Chi: Moving for Better Balance*, and Arthritis Foundation programs.
- 1.4: Increase the number of evidence-based programs, such as *A Matter of Balance*, *Tai Chi: Moving for Better Balance*, and Arthritis Foundation programs, offered to older adults.

Recommendation 2: Improve the safety of the physical environment in homes.

- 2.1: Promote home falls risk assessments based on CDC recommendations.
- 2.2: Increase knowledge of existing resources for home modifications and assistive devices.
- 2.3: Increase resources for home modification and assistive devices.
- 2.4: Implement the Rhode Island Department of Health Emergency Medical Services Home Assessment pilot project.
- 2.5: Educate older adults and their caregivers on the importance of home modifications to prevent falls.

Recommendation 3: Improve the safety of the built environment.

- 3.1: Inform state and local planning agencies about the value of incorporating older adult-friendly sidewalks, public transportation, and public spaces into their comprehensive plans.
- 3.2: Develop an assessment tool for businesses to ensure that their spaces are safe and accessible for older adults, and disseminate the tool throughout the business community.

Recommendation 4: Improve the management of health conditions.

- 4.1: Promote CDC-recommended education on screening for and management of health conditions that put older adults at risk of falls and resulting injuries.
- 4.2: Provide CDC-recommended falls risk assessment screenings and train healthcare providers to refer patients to appropriate preventive services, such as community-based exercise programs, based on assessment results.
- 4.3: Promote and provide regular medication reviews.
- 4.4: Promote and provide regular vision check-ups.
- 4.5: Promote and provide regular hearing check-ups.

Recommendation 5: Increase education, awareness, and knowledge around falls risk and falls prevention strategies.

- 5.1: Enhance awareness of falls as a public health epidemic among the public, older adults, caregivers, and providers.
- 5.2: Educate the public, older adults, caregivers, and providers on strategies for falls prevention.
- 5.3: Disseminate previously developed and tested messages for older adults.
- 5.4: Develop and test additional clear, audience-specific messages for older adults, caregivers, healthcare providers, pharmacists, and community partners.
- 5.5: Develop and test messages targeting the 50- to 60-year-old population for the primary prevention of falls.
- 5.6: Identify and use appropriate communication channels to reach target populations.

Recommendation 6: Minimize injuries resulting from falls.

- 6.1: Increase knowledge of the benefits of having an Emergency Care Plan.
- 6.2: Increase knowledge of existing resources for personal emergency response systems.
- 6.3: Promote tools and falls prevention language to older adults to help them develop strategies to minimize injuries resulting from falls.



MOTOR VEHICLE INJURY PREVENTION

Unintentional Motor Vehicle Injury:

A motor vehicle injury is a result of a motor vehicle collision, which occurs when a vehicle collides with another vehicle, pedestrian, animal, road debris, or other stationary obstruction. Motor vehicle injuries can affect drivers, passengers, pedestrians, motorcyclists, and bicyclists.

Burden of Motor Vehicle Injury:

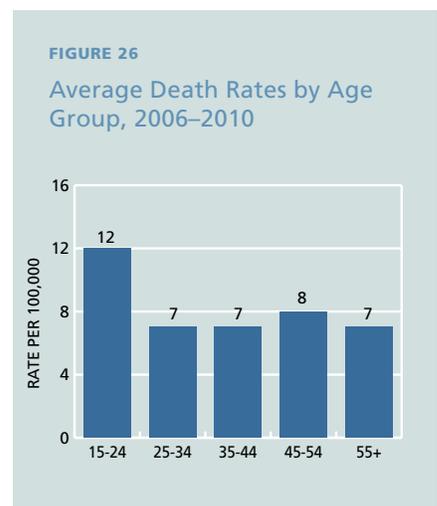
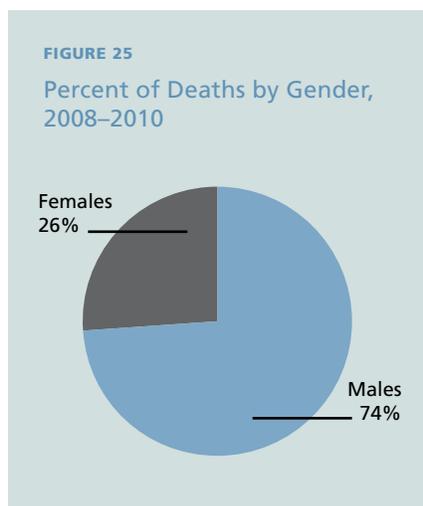
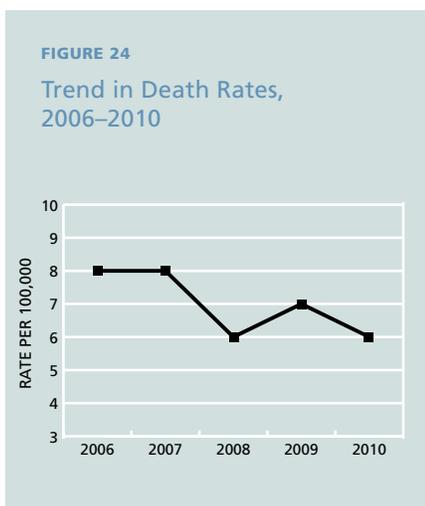
Unintentional motor vehicle injuries are the leading cause of death for young people age 5 through 24 in Rhode Island.¹ Injuries due to motor vehicle crashes make up 11 percent of injury-related deaths, 9 percent of injury-related hospitalizations, and 12 percent of injury-related emergency department visits in Rhode Island for all age groups.²⁰ From 2006-2010, the unintentional motor vehicle death rate remained relatively stable, varying from six to eight per 100,000 population (Figure 24).

The risk of an unintentional motor vehicle crash fatality was higher among males than females (Figure 25). Young drivers were also disproportionately affected by unintentional motor vehicle crashes. The unintentional motor vehicle death rate for drivers age 15 through 24 was nearly twice the rate of the rest of the population at 12 per 100,000 population (Figure 26).

Young drivers also had a disproportionately higher unintentional motor vehicle hospitalization rate and emergency department visit rate in relation to the rest of the population (Figures 27 and 28). From 2008-2010, there were 1,675 hospitalizations and 40,637 emergency department (ED) visits for unintentional motor vehicle-related injuries in Rhode Island (Figure 29).

During 2006-2010, non-Hispanic whites and non-Hispanic blacks had similar hospitalization rates for unintentional motor vehicle injuries, while the hospitalization rate was lower for Hispanics. All three groups had similar unintentional motor vehicle injury-related death rates (data not shown in this chapter).

Rhode Island Fatal Unintentional Motor Vehicle Injuries*



*Rates based on less than 10 events have been suppressed.
Data Source: Rhode Island Vital Records Death Data



Rhode Island Nonfatal Unintentional Motor Vehicle Injuries

FIGURE 27

Average Hospitalization Rates by Age Group, 2006–2010

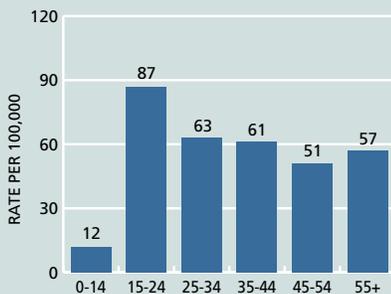


FIGURE 28

Average Emergency Department Visit Rates by Age Group, 2006–2010

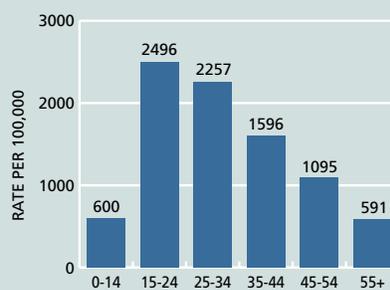
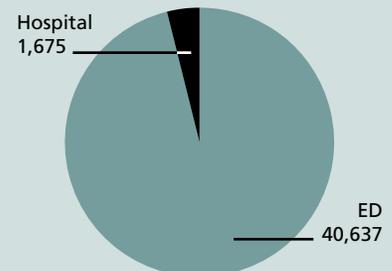


FIGURE 29

Total Number of Injuries, 2008–2010



Data Sources: Rhode Island Hospital Discharge Data, Rhode Island Emergency Department Data



Goal 1: Prevent deaths caused by unintentional motor vehicle crashes in Rhode Island.

Goal 2: Prevent injuries caused by unintentional motor vehicle crashes in Rhode Island.

Objectives:

1. Decrease the rate of deaths due to unintentional motor vehicle crashes in Rhode Island from 7 per 100,000 in 2009 to 5 per 100,000 in 2016.
2. Decrease the rate of hospitalizations due to unintentional motor vehicle injuries in Rhode Island from 58 per 100,000 in 2009 to 54 per 100,000 in 2016.

Priority Populations: The general population
Young people age 15-24

Risk Factors:

- Drinking and driving^{36,37}
- Not wearing a seatbelt^{38,39,40}
- Distracted driving^{41,42}
- Risk-taking behavior (e.g. speeding)^{43,44}
- High job stress⁴⁵
- Prior motor vehicle accident⁴⁵
- Not wearing a motorcycle helmet⁵⁸

Evidence-based strategies:

The Centers for Disease Control and Prevention (CDC) has identified motor vehicle injury as a “winnable battle,” because prevention will have a large-scale public health impact if evidence-based strategies are implemented.⁴⁶ CDC recommends policy and enforcement as effective strategies to prevent motor vehicle-related injuries and deaths, specifically those policies that increase seat belt usage, reduce impaired driving, and increase safety for teen drivers.⁴⁶

Adult seat belt use is the single most effective way to save lives and reduce injuries.⁴⁶ States with a primary seat belt law have higher rates of seat belt use and lower rates of motor vehicle fatalities, in comparison to states with a secondary law or no law.^{47,48,49} Rhode Island passed a temporary primary seat belt law in 2011, and the law became permanent in July 2013. Two goals of the Violence and Injury Prevention Program (VIPP) are to educate decision makers, partners, and the general public on the benefits of seat belt use and to enhance enforcement of the primary seat belt law.

To reduce alcohol-impaired driving, evidence-based strategies include multi-component efforts such as the limiting of access to alcohol and binge drinking (particularly among youth), responsible beverage service training, mass media campaigns, strict ignition interlock policies, and sobriety checkpoints.^{50,51} In Rhode Island, sobriety checkpoints have been deemed unconstitutional, and implementation would require legal changes. The current Rhode Island ignition interlock policy is weak in comparison to other states; it is *recommended* at the third offense of impaired driving. It is a priority of the VIPP to educate decision makers, partners, and the general public on the benefits of a mandatory ignition interlock policy at the first offense of impaired driving.

Graduated driver licensing (GDL) policies limit newly-licensed, young drivers from driving under high-risk conditions, such as driving at night and transporting other teen passengers. These laws are credited with a decline in the number of fatal crashes, injuries, and deaths involving young drivers.^{52,53,54} Although Rhode Island has a comprehensive GDL law in place, strategies to enforce compliance with the law are necessary. For example, the VIPP supports the implementation of a mandatory two-hour parent education class that would result in more effective education about the regulations and safe driving practices for young drivers.

The VIPP will support statewide partners in promoting and implementing evidence-based interventions for motor vehicle death and injury prevention. The Traffic Safety Coalition, which serves as Rhode Island's statewide motor vehicle advisory committee to the VIPP, also recommends the following strategies for statewide implementation. (See Appendix VI for the Traffic Safety Coalition membership list.)

Recommendation 1: Reduce impaired (drugged and drunk) driving fatalities and serious injuries.

- 1.1: Improve access to and credibility of impaired driving data.
- 1.2: Increase public awareness of the dangers of impaired driving.
- 1.3: Strengthen laws on impaired driving.
- 1.4: Improve impaired driving enforcement.
- 1.5: Improve alcohol and drug assessment and treatment.

Recommendation 2: Reduce unbelted fatalities and unbelted serious injuries.

- 2.1: Increase education and outreach efforts about the benefits of safety belt use.
- 2.2: Increase enforcement of occupant protection laws.

Recommendation 3: Reduce young driver-involved fatalities and serious injuries.

- 3.1: Require parents or guardians of young drivers to take two hours of driver's education.
- 3.2: Promote and improve driver's education programs based on what the research indicates is effective.
- 3.3: Increase public outreach and education on the basics of roadway safety, targeting young drivers.
- 3.4: Increase enforcement and publicize enforcement initiatives conducted in the state.

Recommendation 4: Reduce speeding-related fatalities and serious injuries.

- 4.1: Improve the collection of speeding-related, fatal, and serious injury crash data.
- 4.2: Conduct a public education and information campaign to increase awareness of the dangers of speeding.
- 4.3: Enhance enforcement of speeding laws.
- 4.4: Identify engineering countermeasures to mitigate speeding on Rhode Island roadways.

Recommendation 5: Reduce intersection and run-off-the-road fatalities and serious injuries.

- 5.1: Select locations and implement countermeasures with the greatest potential for safety improvement using the predictive methods in the Highway Safety Manual (HSM).
- 5.2: Increase enforcement at locations with the most severe safety needs (e.g., red-light running cameras, automated speed enforcement in work zones and school zones, targeted police enforcement, educational campaigns, etc.).

5.3: Improve safety for vulnerable users (bicyclists, pedestrians, moped users, motorcyclists).

5.4: Continue education and outreach to local jurisdictions to improve safety.

5.5: Develop and implement a safety corridor program.

Recommendation 6: Increase the percentage of motorcycle operators and passengers who always use a motorcycle helmet.

6.1: Increase education and outreach efforts about the benefits of motorcycle helmet use.

6.2: Increase enforcement of current motorcycle helmet laws.

6.3: Strengthen motorcycle helmet laws (e.g. universal motorcycle helmet use law).

Recommendation 7: Reduce distracted driving fatalities and serious injuries.

7.1 Improve access to and credibility of distracted driving data.

7.2 Increase public awareness of the dangers of distracted driving.

7.3 Strengthen laws on distracted driving including bans on the use of hand-held and hands-free devices.

7.4 Improve enforcement of distracted driving laws.



SUICIDE AND SUICIDE ATTEMPT PREVENTION

Suicide:

Self-directed violence that results in death.

Suicide Attempt:

Self-directed, harmful behavior that could result in death in the immediate future.

Burden of Injury from Suicide and Suicide Attempts:

Suicide and suicide attempts are serious and persistent public health problems with devastating effects on victims, families, and communities. Suicidal behavior is a complicated issue that affects all age groups; therefore, a life-course approach has been selected for prevention efforts. In 2008-2010, suicide was among the top four leading causes of death for ages 10 through 44 years in Rhode Island.¹

On average, 119 Rhode Islanders die by suicide each year;¹ however, suicides represent only a fraction of the outcome of suicidal behavior. Non-fatal injuries from suicide attempts are much more common than death by suicide. The Violence and Injury Prevention Program (VIIPP) uses an inpatient hospital admission or an emergency department visit coded as resulting from 'self-harm' injury as a marker for a suicide attempt.

The rate of suicides in Rhode Island increased from 8 per 100,000 population in 2006 to 11 per 100,000 population in 2010 (Figure 30). Among those who died by suicide, the majority (80%) were males (Figure 31). Adults age 35 through 54 were more likely to die by suicide in comparison to all other age groups (Figure 32).

Females had more emergency department visits due to suicide attempts than males (Figure 33). Rhode Islanders age 15 through 34 have the highest rate of emergency department visits for suicide attempts (Figure 34). From 2008-2010, the number of emergency department (ED) visits due to a suicide attempt were over double the number of hospital admissions due to a suicide attempt: 3,980 versus 1,764 respectively (Figure 35). A hospitalization indicates that a more serious suicide attempt was made.

Non-Hispanic whites were more likely to die by suicide than non-Hispanic blacks and Hispanics. Hospitalization rates for attempted suicides were not different for non-Hispanic whites and non-Hispanic blacks, but were lower for Hispanics (data not shown in this chapter).



Rhode Island Suicide Deaths*

FIGURE 30

Trend in Death Rates, 2006–2010

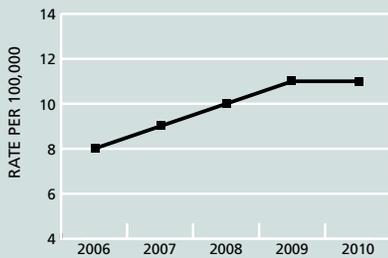


FIGURE 31

Percent of Deaths by Gender, 2008–2010

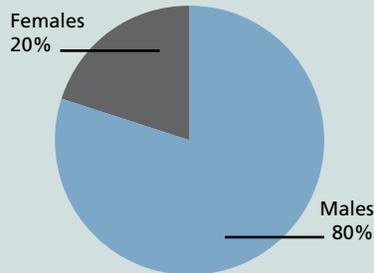
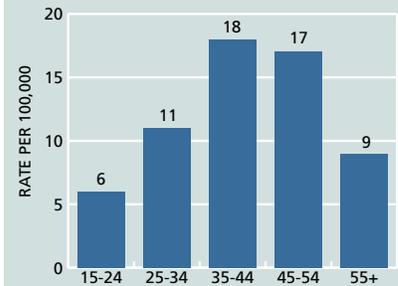


FIGURE 32

Average Death Rates by Age Group, 2006–2010



*Rates based on less than 10 events have been suppressed.
Data Source: Rhode Island Vital Records Death Data

Rhode Island Nonfatal Suicide Attempts

FIGURE 33

Percent of Emergency Department Visits by Gender, 2008–2010

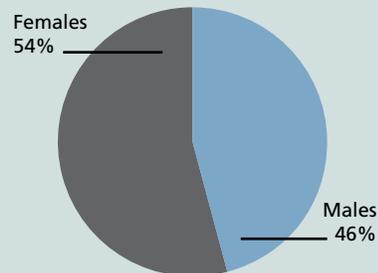


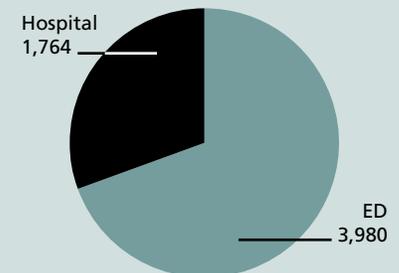
FIGURE 34

Average Emergency Department Visit Rates by Age Group, 2006–2010



FIGURE 35

Total Number of Injuries, 2008–2010



Data Sources: Rhode Island Hospital Discharge Data, Rhode Island Emergency Department Data



Goal 1: Prevent suicides.

Goal 2: Prevent suicide attempts.

Objectives:

1. Decrease the number of deaths due to suicide for 15-24 year olds in Rhode Island's six high-poverty cities from five in 2009 to four in 2016.^{†‡}
2. Decrease the number of hospitalizations due to suicide attempts for 15-24 year olds in Rhode Island's six high-poverty cities from 52 in 2009 to 48 in 2016.

Priority Populations: All ages (life-course approach)
Youth ages 15 through 24

Risk Factors:

- Active military/veteran status⁵⁵
- Psychiatric illness⁵⁶
- Previous suicide attempt/self-harm⁵⁷
- Substance use disorders⁵⁸
- Easy access to lethal means⁵⁷
- Impulsive/aggressive tendencies^{59,60}
- Family history of suicide⁵⁷
- Lack of social support/isolation⁵⁷
- LGBTQ adolescents⁶¹
- Youth with disabilities⁶²

Evidence-based strategies:

Comprehensive suicide prevention programs reduce risk factors and increase protective factors. The factors that contribute to suicidal behaviors are complex and multi-faceted; therefore, prevention efforts should address all levels of influence including individual, relationship, community, and societal.⁶³ The CDC recommends several evidence-based and promising strategies with a focus on strengthening connectedness within and among individuals, families, and communities, interrupting the development of suicidal behavior, integrating approaches to prevent suicidal behavior with approaches to prevent interpersonal violence, and addressing vulnerable populations.⁶⁴

One approach to suicide prevention is gatekeeper training. *Signs of Suicide* (SOS) is an evidence-based, school-based gatekeeper program. It is designed for middle and high school-age students. The program teaches students how to identify the symptoms of depression and suicidality in themselves or their friends and encourages help-seeking through the use of the ACT technique (Acknowledge, Care, Tell).⁶⁵

[†]Cities where the child poverty level is greater than 15%, based on the 2000 US Census, are designated in this report as high-poverty cities. These are Central Falls, Newport, Pawtucket, Providence, West Warwick, and Woonsocket.

[‡]The five suicide deaths were in four of the six core cities (Providence, Pawtucket, West Warwick and Woonsocket).

Another evidence-based gatekeeper program is *Question, Persuade, and Refer* (QPR). This one- to two-hour educational program is designed to teach adult gatekeepers to recognize the warning signs of a suicide and how to respond.⁶⁶ Adult gatekeepers (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, police officers) are strategically positioned to recognize and refer someone at risk of suicide. QPR has been shown to successfully teach workshop participants suicide-specific skills; however, the program does not evaluate participants' actual use of those skills.⁶⁷

The Violence and Injury Prevention Program (VIPP) uses a life-course approach including evidence-based gatekeeper programs and media campaigns such as *Suicide Proofing Your Home* (www.suicideproof.org) for suicide prevention. Early intervention and education about the signs of suicide provide at-risk youth and their mentors the tools and information to identify suicide risk and to seek and/or refer to appropriate help. The VIPP will support statewide partners in the implementation of SOS and QPR. The Youth Suicide Prevention Subcommittee of the Injury Community Planning Group also recommends the following strategies for statewide implementation. (See Appendix VII for the subcommittee membership list.)

Recommendation 1: Recognize people at risk for death by suicide and support treatment for them.

Recommendation 2: Reduce the stigma associated with having a mental illness and/or seeking services for mental health and substance abuse issues.

- 1.1 (2.1): Provide information to individuals and families that increases the acceptability of seeking services and reduces associated stigma.
- 1.2 (2.2): Teach, encourage, and reinforce social/emotional competency broadly in Rhode Island.
- 1.3 (2.3): Provide support groups that build a sense of community to individuals and families.
- 1.4 (2.4): Encourage a safe and nurturing living environment for individuals and families.
- 1.5 (2.5): Educate and assist family, friends, neighbors, and others to understand who is at risk for suicide and how to respond to at-risk individuals.
- 1.6 (2.6): Increase awareness of community resources for suicide prevention and provide suicide prevention information on the Internet.
- 1.7 (2.7): Raise awareness about the dangers of over-the-counter and prescription medications and other lethal means.
- 1.8 (2.8): Raise awareness of the relationship between substance use and suicide.
- 1.9 (2.9): Raise awareness that suicide is a public health problem and that it is preventable through early seeking of help from resources in community, state, and national programs.
- 1.10 (2.10): Conduct a statewide educational campaign to increase the acceptability of seeking services and reduce associated stigma.
- 1.11 (2.11): Improve referral knowledge, efficiency, and effectiveness by all who refer, starting with primary care providers.
- 1.12 (2.12): Partner with the media to provide guidelines on suicide reporting that decrease the likelihood of suicide contagion.
- 1.13 (2.13): Partner with community, voluntary, and faith-based agencies to increase awareness of services among individuals and families in need and promote suicide prevention.
- 1.14 (2.14): Partner with healthcare providers and insurers to improve access to services.
- 1.15 (2.15): Increase the delivery of evidence-based suicide prevention education programs such as *Question, Persuade,*



and Refer (QPR) and *Signs of Suicide* (SOS) in organizations and places where individuals and families congregate, such as schools, parent teacher organizations, faith-based communities, and other community groups.

- 1.16 (2.16): Advocate for increased funding to deliver public awareness campaigns.
- 1.17 (2.17): Provide fact sheets on suicide as a public health issue to legislators.
- 1.18 (2.18): Advocate for adequate mental health service coverage.

Recommendation 3: Improve and expand mental health service delivery.

- 3.1: Improve the coordination of care between behavioral health, primary care, and emergency departments.
- 3.2: Provide information to individuals on existing mental health services and how to access them.
- 3.3: Promote and enhance initiatives that build mental health service capacity.
- 3.4: Provide initiatives to strengthen individuals' emotional competency.
- 3.5: Increase cross-training of health and human services providers related to risk assessment, recognition, treatment management, and aftercare of suicidal individuals.
- 3.6: Increase cross-training of employers and human resources professionals related to risk assessment, recognition, treatment management, and aftercare of suicidal individuals.
- 3.7: Educate healthcare providers about utilizing culturally appropriate suicide interventions.
- 3.8: Improve access to services and reimbursements by building coalitions of state, local, and community-based organizations.
- 3.9: Partner with other state agencies to identify common areas of concern related to mental health service needs of people under their care.
- 3.10: Work with community-based agencies to increase awareness of services among individuals and families in need.

- 3.11: Strengthen resources for volunteer training to increase hotline availability.
- 3.12: Advocate for adequate reimbursement and coverage for mental health and substance abuse treatment services.
- 3.13: Encourage suicide prevention education for all social service providers and clinicians seeking licensure.

Recommendation 4: Increase screening and identification of at-risk individuals.

- 4.1: Support and educate individuals to identify emergency situations and at-risk peers using evidence-based programs such as *Signs of Suicide (SOS)* and *Question, Persuade, and Refer (QPR)*.
- 4.2: Support individuals who seek help for their at-risk friends.
- 4.3: Provide educational programs for family members of persons at elevated risk for suicide.
- 4.4: Educate clergy, healthcare providers (e.g., primary care and emergency department doctors and nurses), medical, social work, and psychology students and faculty, educators, juvenile justice professionals, funeral directors, police and fire department personnel, and other gatekeepers to identify at-risk individuals using evidence-based strategies.
- 4.5: Provide referral information and support to healthcare providers to help them make effective referrals for at-risk individuals.
- 4.6: Screen early and often via healthcare providers (e.g., primary care physicians and home care providers), school-based staff, and community-based agencies.
- 4.7: Annually review data on characteristics of completed and attempted suicides to improve screening tools.
- 4.8: Design or choose an instrument (prompts) for use by healthcare providers (e.g., primary care doctors) to increase screening.
- 4.9: Advocate for coverage and reimbursement for routine screening services.
- 4.10: Expand student assistance programs to every Rhode Island high school.

Recommendation 5: Promote efforts to reduce access to lethal means and methods that result in self-harm or a suicide attempt.

- 5.1: Raise awareness during legislative season about gun-control bills.
- 5.2: Raise awareness through public education campaigns about gun-safety measures and gun-related deaths in Rhode Island.
- 5.3: Educate healthcare and social service providers about the relationship between substance use and other high-risk behaviors and suicide.
- 5.4: Educate healthcare providers, social service providers, and health and safety officials on how to assess the potential for lethal means in the home.
- 5.5: Establish interagency collaborations around support for gun control and gun safety.
- 5.6: Improve communication among healthcare providers.
- 5.7: Educate healthcare providers and pharmacists about over-the-counter medications and suicide prevention (e.g., warning labels for prescriptions).

Recommendation 6: Coordinate and expand public health surveillance of suicide and suicide attempts.

- 6.1: Establish objectives of a public health surveillance system for suicide and suicide attempts.
- 6.2: Using CDC criteria, determine the utility and feasibility of using various data sources or data collection mechanisms for the surveillance of suicide and suicide attempts among Rhode Islanders (e.g. Office of State Medical Examiners files, Hospital Discharge data, Emergency Department data, Emergency Medical Services-run reports, Poison Center data, school-based health center data, Child Death Review Team data).
- 6.3: Research data collection instruments and/or develop them, as needed.
- 6.4: Develop field test methods.
- 6.5: Develop and test an analytic approach.
- 6.6: Develop a dissemination mechanism.
- 6.7: Support the use of suicide data analysis by community partners.

Recommendation 7: Promote and support culturally relevant research on suicide and suicide prevention.

- 7.1: Research and evaluate the potential role and effectiveness of conducting psychological autopsies in Rhode Island.
- 7.2: Research the effectiveness of treatments for suicidal risk.
- 7.4: Evaluate the impact of existing primary prevention programs (e.g. social/emotional competency training, character education, and social/emotional education) on suicide and suicide attempts at Rhode Island hospitals.
- 7.5: Evaluate the accuracy of e-coding (categorizing of injuries and intent) of suicide attempts at Rhode Island hospitals.
- 7.6: Evaluate outcomes of students referred to social service and treatment programs by counseling and support services.
- 7.9: Evaluate suicide prevention interventions.
- 7.10: Clarify risk and protective factors specific to different populations (e.g. demographics, socioeconomic status, religion, participation in extracurricular activities, etc.)
- 7.11: Research and develop culturally relevant messages.

Recommendation 8: Promote administrative and legislative strategies that support suicide prevention.

- 8.1: Mandate teacher training in *Question, Persuade, and Refer* (QPR) for secondary and higher education and juvenile justice.

CONCLUSION

The last five to ten years have presented new and ongoing challenges for injury prevention in Rhode Island. Unintentional poisoning due to drug overdose is a public health epidemic that has grown at an unprecedented rate and has been the leading cause of injury-related death in Rhode Island since 2008. Deaths due to unintentional falls have consistently been in the top two causes of injury-related death since 2003. In 2006, the suicide death rate surpassed the unintentional motor vehicle-related death rate in Rhode Island. This trend has persisted over the past four years (2006-2010). Deaths due to unintentional motor vehicle crashes continue to contribute significantly to the burden of injury in Rhode Island.

Despite these challenges, the Violence and Injury Prevention Program (VIIPP) and its community partners have made great progress in making Rhode Island a safer state. Each of the Injury Community Planning Group subcommittees has been successful in implementing interventions that will ultimately lead to a reduction in the burden of injury in Rhode Island, including:

- Electronic access to the Prescription Monitoring Program by healthcare providers in 2012.
- Evidence-based falls management programs starting in 2011.
- Strategies to increase seatbelt use (passage of the Primary Seatbelt Law in 2011, which was made permanent in 2013).
- Evidence-based gatekeeper training programs to prevent suicide in 2009.

These successes represent just a few of the injury prevention efforts currently being implemented in Rhode Island. The VIIPP encourages partners to use the data and recommendations in this plan to drive injury prevention work. Together, the VIIPP and its partners can help save lives and improve the quality of life for Rhode Islanders.



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APPENDICES

Appendix I: Health Equity Pyramid



The Health Impact Pyramid, April 2010, Vol 100, No. 4, American Journal of Public Health. This Pyramid is adapted from Thomas Frieden, MD, MPH, presentation at the Weight of the Nation conference, Washington D.C., July 27, 2009

Appendix II: Injury Community Planning Group Steering Committee Structure

Chair:

Michael Mello
Director of Injury Prevention
Injury Prevention Center
Rhode Island Hospital

Staffed by:

Jennifer Andrade Koziol
Program Coordinator
Violence and Injury Prevention Program
Rhode Island Department of Health

Membership:

Traci Green
Drug Overdose Prevention and Rescue
Subcommittee Chair
Brown University
Rhode Island Hospital

Jeffrey Hill
Program Coordinator
Violence and Injury Prevention Program
Rhode Island Department of Health

Francisco Lovera
Motor Vehicle Injury Prevention
Subcommittee Representative
Rhode Island Department of Transportation

Dina Morrissey
Program Coordinator
Injury Prevention Center
Rhode Island Hospital

Deborah Pearlman
Program Evaluator
Violence and Injury Prevention Program
Rhode Island Department of Health
Brown University

Beatriz Perez
Program Manager
Violence and Injury Prevention Program
Rhode Island Department of Health

Sara Remington
Childhood Maltreatment Prevention Representative
Early Childhood Home Visiting Program
Rhode Island Department of Health

Leigh Reposa
Suicide Prevention Subcommittee Chair
Rhode Island Student Assistance

Rhonda Schwartz
Fall Injury Prevention Subcommittee Chair
Rhode Island Division of Elderly Affairs

Appendix III: Data Sets

Rhode Island Hospital Discharge Data (RI HDD)

Data on inpatient discharges come from Rhode Island's 14 non-federal short-stay hospitals, including five teaching hospitals providing general acute care, six other general acute-care hospitals, two psychiatric teaching hospitals, and one inpatient rehabilitation facility. The data are based on hospital discharges rather than hospital admissions in order to capture length of stay and hospital charges. The Hospital Discharge Data include clinical diagnoses, procedures, and hospital charges. Information also is available on patient demographics (age, sex, race/ethnicity, town and zip code of residence) and source of payment. The data can be used to measure health status and outcomes and healthcare utilization, and for disease and injury surveillance. Patients who die in the hospital are included in the dataset. Hospitals report inpatient discharge data to the RI Department of Health's Center for Health Data and Analysis within 90 days after the end of each calendar quarter. Rhode Island began surveillance for hospital discharges in 1990.

Emergency Department (ED) Visit Data and Observation (OBS) Data

Data on emergency department visits and observation stays are collected from Rhode Island's non-federal short-stay hospitals. The dataset only includes emergency department visits where the patient was discharged home. These events represent cases that are generally less severe than inpatient hospital cases. Information on clinical diagnoses, procedures, and emergency room charges can be used to measure health status and outcomes and emergency department utilization, and for disease and injury surveillance. Information also is available on patient demographics. Hospitals report emergency department visit data to the RI Department of Health's Center for Health Data and Analysis within 90 days after the end of each calendar quarter. Rhode Island began surveillance for emergency department visits in 2005.

Rhode Island Vital Records (Death Records)

Death data are collected from funeral directors who are responsible for obtaining the cause of death from physicians. The definition of a case or record in the Death Records is a person who died in RI or a RI resident who has died out-of-state. Preliminary data on deaths occurring in RI are available within one year after the end of the calendar year. Final data, including out-of-state deaths of RI residents, are available 2 years after the end of the calendar year. Data collection is ongoing.

National Injury Data

The Centers for Disease Control and Prevention support an interactive public use database system known as WISQARS™ (Web-based Injury Statistics Query and Reporting System). The data include fatal and nonfatal injuries, violent deaths, and cost of injuries. Information can be used to assess the public health and economic burden associated with unintentional and violence-related injury in the United States. Users can view the injury data and create reports, charts, and maps based on the following:

- Intent of injury (unintentional injury, violence-related, homicide/assault, legal intervention, suicide/intentional self-harm)
- Mechanism (cause) of injury (e.g., fall, fire, firearm, motor vehicle crash, poisoning, suffocation)
- Body region (e.g., traumatic brain injury, spinal cord, torso, upper and lower extremities)
- Nature (type) of injury (e.g., fracture, dislocation, internal injury, open wound, amputation, burn)
- Geographic location (national, regional, state) where the injury occurred
- Sex, race/ethnicity, and age of the injured person

The query system is available online at: <http://www.cdc.gov/injury/wisqars/index.html>

Appendix IV: The Drug Overdose Prevention and Rescue Subcommittee Membership List*

Chair:

Traci Green
Rhode Island Hospital
Brown University

Staffed by:

Jennifer Andrade Koziol
Violence and Injury Prevention Program
Rhode Island Department of Health

Membership:

Rebecca Boss
Rhode Island Department of Behavioral Healthcare,
Developmental Disabilities and Hospitals

Sarah Bowman
Rhode Island Hospital

Jef Bratberg
University of Rhode Island, College of Pharmacy
Rhode Island Pharmacist Association

Holly Cekala
ANCHOR
Rhode Island College

Joseph Coffey
Warwick Police Department

Leslie Cohen
New England Addiction Technology
Transfer Center (ATTC) Network

Cathy Cordy
Prescription Monitoring Program
Rhode Island Department of Health

Chris Creech
Healthy Communities Office
City of Providence

Lori Dorsey
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Developmental Disabilities and Hospitals

Timothy Dutra
Rhode Island resident

Lauranne Howard
Rhode Island Department of Corrections

Patrick Kelly
Board of Pharmacy
Rhode Island Department of Health

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Rhode Island Department of Behavioral Healthcare,
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Todd Manni
Emergency Medical Services
Rhode Island Department of Health

Brandon Marshall
Brown University

Michelle McKenzie
Miriam Hospital

Valeri Melekhov
Rhodes Technologies

Obad Papp
Mayor's Substance Abuse and Prevention Council
City of Providence

Beatriz Perez
Violence and Injury Prevention Program
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Matthew Raymond
Prescription Monitoring Program
Rhode Island Department of Health

Jason Rhodes
Emergency Medical Services
Rhode Island Department of Health

Michael Rizzi
CODAC Behavioral Healthcare

George Stamatakos
Providence Police Department

*This list includes all partners that participated in the strategic planning process (November 2012 – May 2013).

Appendix V: The Falls Injury Prevention Subcommittee Membership List[†]

Chair:

Rhonda Schwartz
Fall Injury Prevention Subcommittee Chair
Rhode Island Division of Elderly Affairs

Staffed by:

Jennifer Andrade Koziol
Violence and Injury Prevention Program
Rhode Island Department of Health

Membership:

Lisa Aubin
Hallworth House

Jenn Bergeron
Executive Office of Health and Human Services
Xerox State Healthcare, LLC

Greg DeGasper
Dwell at Ease

Shayne Donahue
Tri-town ElderCare

Susan Dugan
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Jane Eskelund
Rebuilding Together

Catherine A. Gergora
Alliance for Better Long Term Care

Cynthia Graves
West Bay Community Action Program
YMCA of Greater Providence

Celeste Harris
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Janice Hulme
University of Rhode Island Physical Therapy Program

Elaine Joyal
Memorial Hospital of Rhode Island

Edna Kurtzman
Bayside YMCA

Jennifer Lee
VNA of Care New England

Kelly Lockwood
Tamarisk Assisted Living Residence

Martha Machnik
YMCA of Greater Providence

Bob McManus
Providence Tai Chi

Amy Mochel
Federal Hill House Association

Beatriz Perez
Violence and Injury Prevention Program
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Lisa Piscatelli
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Gerry Plante
Safely Home

Vinny Quintero
Rhode Island Fire Marshall

Jennifer Reid
Executive Office of Health and Human Services
Xerox State Healthcare, LLC

Tara Treffry
Federal Hill House Association

[†]This list includes all partners that participated in the strategic planning process (December 2012 –April 2013).

Appendix VI: The Traffic Safety Coalition Membership List[†] (Serves as the Motor Vehicle Injury Subcommittee)

Chairs:

Gabrielle M. Abbate
MADD Rhode Island

Lloyd Albert
Dave Raposa
AAA Southern New England

Commissioner Steven Pare
Commissioner of Public Safety for the City of Providence

Richard Sullivan
Police Chief's Association

Staffed by:

Robert P Feltz
Volunteer

Membership:

Cathy Andreozzi Tori Lynn Andreozzi Foundation	Despina Metakos Rhode Island Department of Transportation
Sergeant Ann Assumpico Rhode Island State Police	Albert Milikian Jr. Community Advocate
James Barden Rhode Island Department of Transportation	Dina Morrissey Injury Prevention Center
Trooper Amanda Brezniak Rhode Island State Police	Anthony Napoli Lifespan
Sharon Brinkworth Brain Injury Foundation	Colonel Steven O'Donnell Rhode Island State Police
Gabe Cano National Highway Traffic Safety Association	Beatriz Perez Violence and Injury Prevention Program Rhode Island Department of Health
Colonel Hugh Clements Providence Police	Major Karen Pinch Rhode Island State Police
Nancy Devaney Narragansett Prevention Partnership	Steven Pristawa Rhode Island Department of Transportation
Mike Geraci National Highway Traffic Safety Association	Alison Riese Lifespan
Kyle Girgan Center for Southeast Asians	Bob Rocchio Rhode Island Department of Transportation
Sergeant Matthew Kite Cranston Police Department	Jacinda Russell USDOT - Federal Highway Administration
Jennifer Andrade-Koziol Violence and Injury Prevention Program Rhode Island Department of Health	Anthony Silva Rhode Island Division of Motor Vehicles
Joe Lindbeck Attorney General's Office	Gregory Smolan Amica
Francisco Lovera Rhode Island Department of Transportation	Jay Sullivan Rhode Island Attorney General's Office
Mark Male Independent Insurance Agents of RI	Sergeant Paul Zienowicz Providence Police

[†]This list includes all partners that participated in the strategic planning process (October 2012 – May 2013).

Appendix VII: Suicide Prevention Subcommittee Membership List

Chair:

Leigh Reposa
Rhode Island Student Assistance Services

Staffed by:

Jeffrey Hill
Violence and Injury Prevention Program
Rhode Island Department of Health

Membership:

Ralph Apici
The Providence Center
Vernia Carter
Progreso Latino
Danielle Cote
Brown University
Chuck Cudworth
Rhode Island Student Assistance Services
Sarah Dinklage
Rhode Island Student Assistance Services
Christine Emond
Gateway Healthcare
Kimberly Gleason
American Foundation for Suicide Prevention
Karyn Horowitz
Bradley Hospital

Elizabeth Kretchman
Rhode Island Department of Behavioral Healthcare,
Developmental Disabilities, and Hospitals
Faith LaMunyon
Rhode Island National Guard/Healthnet
Christine Miller
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Appendix VIII: Acknowledgements

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Environmental Factor # 20 – Suicide Prevention

In Rhode Island, the Department of Health is the lead agency for suicide prevention. Its last Injury Prevention Plan, “Preventing Violence and Injuries in Rhode Island: 2011-2016 Rhode Island Strategic Plan,” was revised in 2013. This plan has an emphasis on reducing underlying circumstances that lead to suicide in the most high risk populations. A comprehensive and coordinated public health approach, including a suicide prevention plan, was developed. Although this plan will remain in effect until the end of calendar year 2016, efforts have already begun to assure that a new plan will be written by that time. This effort is being coordinated by Jeff Hill, the Rhode Island Department of Health’s Youth Suicide Prevention Project Coordinator. As does the present Report, the new Report will incorporate recommendations from the “National Strategy for Suicide Prevention.” It should be noted that the present state plan is cited as a model in the “Guidance for State Suicide Plan Leadership and Plan” for its data-driven approach to planning.

The present plan does not specifically identify the Block Grant priority populations as its focus, but its recommendations regarding reducing stigma, improving mental health service delivery, increasing screening and identification of at-risk individuals, expanding public health surveillance and promoting culturally relevant research are relevant to and consistent with the SAMHSA’s strategies for these populations.

The Rhode Island Department of Health (DOH) has a federal Garrett Lee Smith Memorial grant to fund the Rhode Island Suicide Prevention Project. BHDDH has a collaborative relationship with the Department of Health (DOH) and sits on the Suicide Prevention Subcommittee, which oversees the project. The focus population is youth and young adults up to age 24. This initiative has implemented education programs in schools and community organizations around the state. The grant helps the project screen and refer those at risk for suicide. The project currently operates in Rhode Island’s three core cities, as well as other cities and towns. Middle and high school staff in these cities are trained to recognize the signs of suicidality and to make appropriate referrals for at-risk individuals. The grant enhances the effectiveness of a state-funded initiative that trains only school health educators by training all school staff to provide standardized screening and referral. The project is extending its work in the core city middle and high-schools to include collaborations with most of the state’s colleges and universities. The project also participates with the VA Medical Centers OEF/OIF/OND Community Task Force that includes the VA, Vet Center, and Rhode Island National Guard.

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Support of State Partners

BHDDH, as the SSA and SMHA, relies on our partners within state government to ensure that individuals served have access to the appropriate services including education employment, health, social services and supports. BHDDH also partners with the Department of Corrections and the Department of Children, Youth and Families to provide supports and assistance to individuals in the adult and juvenile justice system have the opportunities to transition successfully into the community.

The following Departments actively participate in the Block Grant Planning process and have submitted letters of support:

1. Department of Children, Youth and Families
2. Department of Corrections
3. Department of Education
4. Department of Health
5. Department Human Services
6. Executive Office of Health and Human Services
7. Department of Labor and Training
8. Office of the Mental Health Advocate
9. Office of Housing and Community Development

DCYF works collaboratively with the sister state agencies under the Executive Office of Health and Human Services to coordinate efforts for families in need of basic needs assistance, early child development services that are supported through the maternal Child Health Home Visiting (MCHHV) programs with the Department of Health (DOH), Head Start and Early Head start through the Department of Human Services (DHS), other Medicaid covered services through EOHHS, and Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) which provides adult mental health services and behavioral health services for adults and youth.

DCYF is working with the RI Family Court, Hasbro Children's Hospital, local law enforcement officials, Homeland Security and Day One, (RI sexual assault and trauma resource center) to develop protocol to promote safe transition to independence by reducing risk that youth and young adults in child welfare system will be victims of trafficking.

DCYF has a strong history of working collaboratively with state and local educational institutions to coordinate planning with early childhood, early education and the elementary and secondary school partners. DCYF is represented on a variety of educational groups including the RI Special Education Advisory Committee, the RI Transition Council, Shared Youth Vision (led jointly by the Department of Labor and Training and the RI Department of Elementary and Secondary Education).

Child Welfare Advisory Committee Subcommittee on the Education of Children and Youth Involved with DCYF developed a report that was submitted to the General Assemble with a recommended framework to ensure that children birth to 5 in DCYF care are adequately prepare and supported for educational achievement. Another Joint Legislative Task Force and Child Welfare Advisory Committee (CWAC) Subcommittee on the Education of Children and Youth involved with DCYF will be developing and implementing a more effect truancy component. (P64 ivb)

DCYF has been working closely with the RI Department of Education (RIDE) and the Department of Health in developing an early childhood service system. Over the past five years and with support from grants, DCYF has been able to strengthen the service array for families with young children and expanded resources and support for the youngest and most vulnerable children. An example of this support and collaboration is a recent educational offering entitled Understanding the Early Childhood Service System: Supports and Resources for Families Involved with DCYF. The trainers include representation of DCYF, an RN who is the DCYF CAPTA liaison for Early Intervention, and Educational Specialist and representative from the RIDE Early Learning and Development Standards Project.

Currently DCYF has been working on developing a partnership for shared data with the Department of Education to improve educational success for children and youth in DCYF care. This data system alignment will improve the delivery of service to children and youth and provide a base for data analysis to improve practices.

State of Rhode Island and Providence Plantations



DEPARTMENT OF HUMAN SERVICES
Office of the Director

August 24, 2015

Maria Montanaro, Director
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
14 Harrington Road
Cranston, RI 02920

Director Montanaro,

As the Director of the Rhode Island Department of Human Services (RIDHS), it is my pleasure to provide the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RIBHDDH) with a letter of support as you apply for the Substance Abuse and Mental Health Block Grant.

The Rhode Island Department of Human Services (RIDHS) administers Temporary Assistance for Needy Families (RIWorks), the Child Care Assistance Program, Supplemental Nutrition Assistance (SNAP), Long-Term Care, General Public Assistance, State Supplemental Payment, Low-Income Home Energy Assistance, Weatherization Assistance Program, Eligibility for Medicaid, and the Administration of Grants: Community Service Block Grant, Social Services Block Grant, Family Violence Prevention Services Grant; Refugee Resettlement Grants, Emergency Food Assistance Program grants, and state Domestic Violence grants.

Additionally, the department administers programs and services for specific populations and needs through its Division of Elderly Affairs, Division of Veterans Affairs, Office of Child Support Services, and Office of Rehabilitation Services. The department is also a member of the Governor's Council on Behavioral Health (GCBH), the planning body for the Mental Health and Substance Abuse Block Grant.

RIDHS leverages behavioral health services by collaborating with RIBHDDH through the block grants and our shared populations, including veterans, elders with behavioral health disorders and women with dependent children, all prioritized populations for services offered by the Mental Health and Substance Abuse Block Grant. The RIDHS and RIBHDDH plan collaboratively to ensure that we are addressing gaps in services and creating a continuum of services for individuals and families with mental health and substance use disorders.

57 Howard Avenue, Cranston, R.I. 02920, (401)462-2121 TDD:(401)462-3363 Fax (401)462-1846



Melba Depeña Affigne, Director

RIDHS will continue to work cooperatively with RIBHDDH and the Governor's Council on Behavioral Healthcare to ensure that our policies, programs and practices are meeting the needs of individuals with mental health and substance use disorders and the departments are able to leverage opportunities to increase access to services.

Sincerely,

A handwritten signature in blue ink, appearing to read "Melba Depeña Affigne", is written over the typed name and title.

Melba Depeña Affigne
Director



Department of Corrections

Ashbel T. Wall, II, Director
40 Howard Avenue
Cranston, RI 02920

Tel: (401) 462-2611
Fax: (401) 462-2630
TDD: (401) 462-5180

August 24, 2015

Maria Montanaro, Director
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH)
14 Harrington Road
Cranston, RI 02920

Dear Director Montanaro,

As the Director of the Department of Corrections (RIDOC), it is my pleasure to provide BHDDH with this letter of support for the 2016-2017 Substance Abuse and Mental Health Block Grant.

RIDOC is an active participant on the Governor's Council on Behavioral Health (GCBH) which, as you know, acts as the planning body for the Mental Health and Substance Abuse Block Grant. Representatives from our agency attend the monthly meetings of the GCBH and work collaboratively with BHDDH's Policy and Planning Unit to identify opportunities in the area of behavioral health services for our shared population both while they are incarcerated and as they are released. Our two departments also work together through the Byrne JAG program to provide transitional housing and treatment programs for individuals with substance use disorders who are reentering the community. Most recently, BHDDH and RIDOC collaborated on the Offender Reentry Program application submission. If awarded, funds will provide mental health and substance abuse screening and assessment to individuals aged 18-26 while they are in prison and also treatment following release.

Our Department is committed to continuing its cooperative activities with BHDDH and the Governor's Council on Behavioral Healthcare to ensure that our policies, programs and practices meet the needs of individuals with mental health and substance use disorders. This partnership will enhance the ability of each of our Departments to leverage opportunities for increasing access to services.

Sincerely,

A.T. Wall II, Director
RI Department of Corrections



Department of Health

Three Capitol Hill
Providence, RI 02908-5097

TTY: 711
www.health.ri.gov

August 24, 2015

Maria Montanaro, Director
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
14 Harrington Road, Cranston, RI 02920

Director Montanaro,

As the Director of the Department of Health, it is my pleasure to provide the Department with of letter support for the Substance Abuse and Mental Health Block Grant.

The Department of Health is an active participant in the Governor's Council on Behavioral Health (GCBH), the planning body for the Mental Health and Substance Abuse Block Grant.

The Department of Health and its staff actively participate on the Governor's Council, including the Prevention Advisory Sub-Committee, Healthy Youth Transitions State-wide Advisory Sub-Committee, and the Healthy Transitions Finance Plan. Department of Health staff also participate on other departmental committees including the Health Transitions communications committee, and work cooperatively through contracts for student assistance services in schools.

The Department will continue to work cooperatively with BHDDH and the Governor's Council on Behavioral Healthcare to ensure that our policies, programs and practices are meeting the needs of individuals with mental health and substance use disorders and the Departments' are able to leverage opportunities to increase access to services.

Sincerely,

A handwritten signature in black ink, appearing to read "Nicole Alexander-Scott".

Nicole Alexander-Scott, MD, MPH
Director
Department of Health



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Administration
OFFICE OF HOUSING AND COMMUNITY DEVELOPMENT
One Capitol Hill
Providence, RI 02908

August 24, 2015

Maria Montanaro
Director
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
14 Harrington Road
Cranston, RI 02920

Director Montanaro:

As the Chief of the Office of Housing and Community Development (OHCD), it is my pleasure to provide the Department with of letter support for the Substance Abuse and Mental Health Block Grant.

The OHCD is a member of the Governor's Council on Behavioral Health (GCBH), the planning body for the Mental Health and Substance Abuse Block Grant. The Office of Housing and Community Development administers the federal Community Development Block Grant (CDBG), Emergency Solutions Grant programs and leads the Housing Resource Commission, where the Rhode Island Continuum of Care is located. These programs target individuals experiencing homelessness and extremely low and low income households in need of affordable housing and supportive services. The OHCD and BHDDH plan collaboratively to ensure the programs administered are providing the services and housing needed to address issues experienced by our shared populations.

The Office will continue to work cooperatively with BHDDH and the Governor's Council on Behavioral Healthcare to ensure that our policies, programs and practices are meeting the needs of individuals with mental health and substance use disorders and the Departments are able to leverage opportunities to increase access to services.

Sincerely,

Michael Tondra
Chief



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Administration
OFFICE OF HOUSING AND COMMUNITY DEVELOPMENT
One Capitol Hill
Providence, RI 02908

August 24, 2015

Maria Montanaro
Director
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
14 Harrington Road
Cranston, RI 02920

Director Montanaro:

As the Chief of the Office of Housing and Community Development (OHCD), it is my pleasure to provide the Department with of letter support for the Substance Abuse and Mental Health Block Grant.

The OHCD is a member of the Governor's Council on Behavioral Health (GCBH), the planning body for the Mental Health and Substance Abuse Block Grant. The Office of Housing and Community Development administers the federal Community Development Block Grant (CDBG), Emergency Solutions Grant programs and leads the Housing Resource Commission, where the Rhode Island Continuum of Care is located. These programs target individuals experiencing homelessness and extremely low and low income households in need of affordable housing and supportive services. The OHCD and BHDDH plan collaboratively to ensure the programs administered are providing the services and housing needed to address issues experienced by our shared populations.

The Office will continue to work cooperatively with BHDDH and the Governor's Council on Behavioral Healthcare to ensure that our policies, programs and practices are meeting the needs of individuals with mental health and substance use disorders and the Departments are able to leverage opportunities to increase access to services.

Sincerely,

Michael Tondra
Chief

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁹⁷

Additionally, [Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. 300x-51\)](#) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC: States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*⁹⁸

⁹⁷<http://beta.samhsa.gov/grants/block-grants/resources>

⁹⁸There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental factors 23 – Planning Council

1. *How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).*

A Block Grant Planning Committee of the Governor's Council was formed and had its first meeting with the BHDDH and DCYF Block Grant Writing Team in May, 2015. The Team presented detailed updates on the structure and progress of the Block Grant Application, on funding proposals for the use of the grants and other matters at the Council's monthly meetings in July and August. A final meeting to review the draft of the Application was held with members of the Governor's Council on 8/25/15. The Application was amended to include corrections proposed by the Council, and members were asked to submit comments for inclusion with the Application. The Council agreed to join the Block Grant Planning Team for the 2017 Application, which will convene in September, 2015.

2. *What mechanism does the state use to plan and implement substance abuse services?*
Like mental health services, substance abuse services are planned by BHDDH and the Executive Office of Health and Human Services/Medicaid with the advice of the Governor's Council on Behavioral Health

3. *Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?*

Rhode Island's state planning council, the Governor's Council on Behavioral Health, has been an integrated behavioral health planning council by state statute since 2002. This integration was enhanced by two SAMHSA-supported capacity building grants in 2013-2014. It is fully integrated mental health and substance abuse prevention, treatment and recovery advisory body.

4. *Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?*

The Council includes members of the state's ethnic, linguistic and racial populations, families of children with SED and SMI, and other important constituencies, such as veterans. Its statutorily limited number of public members presents challenges in representing the full diversity in the state, but diverse representation is a key criteria in selecting new members. It is also important to note that the Council has a number of non-members who attend and participate regularly, which allows it to broaden its representation.

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

The Council has members representing people in recovery from both mental and substance use disorders, family members, veterans and others. Members also represent the various practices of prevention, early intervention, treatment and recovery. In addition to direct input from those attending meetings, the Council has a large email list which functions to involve individuals who cannot attend meetings. Finally, because many members represent advocacy groups, the Council's discussions can include input from, and spread information to, a larger community.

The Governor's Council is responsible to carry out the duties cited in the law governing state mental health planning councils. In addition, state law requires it to:

- (1) To review and evaluate the behavioral health needs and problems in the state and propose such recommendations as are appropriate;
- (2) To stimulate and seek the development and coordination of all programs relating to behavioral health, including but not limited to, such areas as care and treatment, prevention, manpower, research and public education;
- (3) To encourage interdisciplinary approaches to combating, treating and preventing substance abuse and mental illness, focusing in particular on integrating support systems for behavioral health care;
- (4) To act as the advisory committee to the department of mental health, retardation and hospitals and the governor on any funds made available to the department by the federal government for substance abuse and/or mental health treatment and prevention purposes;
- (5) To stimulate and investigate research as it affects planning and implementation of behavioral health care systems in the health care environment;
- (6) To make an annual report to the governor and the general assembly during the month of January, setting forth:
 - (i) The nature and extent of the behavioral health care problems in the state;
 - (ii) Such information and recommendations as the council deems necessary to deal with the problems as documented;
 - (iii) A review of the council's activities during the preceding year, including but not limited to, reports relative to activity, performance and need;
 - (iv) Any plans developed by the council to deal with the behavioral health care problems identified by the council;
 - (v) Other recommendations as may be appropriate and in the public interest.

Meeting to discuss the Draft of the 2016 SA and MH Block Grant Application for the Governor's Council on Behavioral Health

Meeting held in Barry 126 on Tuesday, August 26, 2015 from 3:00 to 4:30 pm

Attendees: Rich Leclerc (Chair), Rosemary Petteruti (staff), Colleen Polselli, Mehan Clingham, Anne Mulready, Lisa Conlan, George O'Tolle, Brian Sullivan, Ranny Dougherty, Jim Dealy (staff), Mark Field, Michelle Brophy, Cherie Cruz, Jim McNulty, Sandra Delsesto, Lisa Tomasso

Comments and suggestions on the proposed draft:

- Rich suggested that an advisory letter be written. There should be some input for the understanding of the allocation of dollars. There is an understanding that the need is greater than the funds.
- Ann asked if the report is made public.
- Discussion over where the term 'co-single' came from. The term comes from SAMHSA. It was stated that the correct term to be used is 'co-Single State Agency'.
- Are we able to get more data from NHP and other places?
- The Council has a list of priorities. Everyone needs to know what we are/are not funding.
- MH tie in to specific funding. What was implemented
- Block Grant – there is no one-on-one reporting for funding
- The aim is to matrix funding
- Transitional age youth – need to know where the needs are
- To fund a new program, one has to be cut
- The Block Grant is one way to get at priorities
- Re Step 2: needs assessment for the youth treatment planning grant
- Do we use money to build better info structure or for programs?
- We need an executive summary
- Use peers for support services
- Re Veterans: this needs to be looked at for next year. Need more outreach and partnership programs
- Re Critical Gap (under the unmet needs, item 5) – there is something missing before the word data.
- Will there be funding for adolescents treatments/residential centers?
- Can money be moved around within the grant once approved or does reconstructed based on previous year and outcome?
- Next step: Jim asked for everyone to email him comments by Thursday. He needs a better version by Friday so he can get it in by next Tuesday.

Governor's Council Strategic Planning/Block Grant Committee
2/14/14

Present:

Cherie Cruz
Ranny Dougherty
Rich Leclerc
Richard Antonelli
Corinna Roy
Fred Trapassi
Jim Dealy

Questions were raised about whether any BG money will be freed up in FY 14 due to the re-funding of RISAPA by the Legislature.

The request was made to get an accounting of the actual BG expenditures. Jim will look into this.

We went over the committee's priorities for Block Grant funding:

- Transitional age youth
- Performance and outcome data capacity
- Parent support programs
- Supplementary funding for children's EBP services that are not fully covered by the MCOs
- Expansion of the Student Assistance Programs' capacity for interventions like SBIRT
- Services for Vets without Tri-Care eligibility
- Peer Support Recovery Coaches
- BH Workforce development
- Respite services
- Adolescent Suicide prevention
- Anchor I and II

(We noted that Anchor was funded in this year's BG)

When the whole Council voted on these priorities, the first three got the overwhelming number of votes, with the first two tied.

We determined that we need to develop a pilot proposal for the transitional youth, either as a recommendation from the committee or in the form of an RFP.

*Plus FY12⁰
FY13 ? FY14*

A. Framework for Planning—Mental Health and Substance Abuse Prevention and Treatment

States should identify and analyze the strengths, needs, and priorities of the state’s behavioral health system. The strengths, needs, and priorities should take into account specific populations that are the current focus of the block grants, the changing health care environment, and SAMHSA’s Strategic Initiatives.

The MHBG program is designed to provide comprehensive community mental health services to adults with SMI or children with SED. For purposes of block grant planning and reporting, SAMHSA has clarified the definitions of SED and SMI. States may have additional elements that are included in their specific definitions, but the following provides a common baseline definition.

Children with SED refers to persons from birth to age 18 and adults with SMI refers to persons age 18 and over; (1) who currently meets or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) who displays functional impairment, as determined by a standardized measure that impedes progress towards recovery and substantially interferes with or limits the person’s role or functioning in family, school, employment, relationships, or community activities.

The SABG block grant program provides substance abuse prevention and treatment services (and certain related activities) to at-risk individuals or persons in need of treatment. See 42 U.S.C. §§ 300x-300x-66.

At a minimum, the plan should address the following populations as appropriate for each block grant (**Populations that are marked with an asterisk are required to be included in the state’s needs assessment for the MHBG or SABG. To the extent that the other listed populations fall within any of the statutorily covered populations, states must include them in the plan*)

1. Comprehensive community-based mental health services for adults with SMI and children with SED:

- Children with SED and their families*
- Adults with SMI*
- Older Adults with SMI*
- Individuals with SMI or SED in the rural and homeless populations, as applicable*

2. Services for persons with or at risk of having substance use and/or SMI/SED:

- Persons who are intravenous drug users (IVDA)*
- Adolescents with substance abuse and/or mental health problems
- Children and youth who are at risk for mental, emotional, and behavioral disorders, including, but not limited to, addiction, conduct disorder, and depression
- Women who are pregnant and have a substance use and/or mental disorder*
- Parents with substance use and/or mental disorders who have dependent children*
- Military personnel (active, guard, reserve, and veteran) and their families
- American Indians/Alaska Natives
- Unaccompanied minor children and youth¹⁴

¹⁴ Section XXX of the Public Health Service Act does not prohibit the provision of these services. 16

3. Services for persons with or at risk of contracting communicable diseases:

- Individuals with tuberculosis* and other communicable diseases
- Persons living with or at risk for HIV/AIDS and who are in need of mental health or substance abuse early intervention, treatment, or prevention services*¹⁵
- The National HIV/AIDS Strategy (NHAS) for the United States and NHAS Implementation Plan¹⁶
- Prevention of HIV among substance users; substance use is associated with a greater likelihood of acquiring HIV infection. HIV screening and other comprehensive HIV prevention services should be coupled with substance treatment programs

¹⁵ For the purpose of determining the states and jurisdictions which are considered “designated states” as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the CDC, National Center for HIV/AIDS, Hepatitis, STD, and TB Prevention. The HIV Surveillance Report, Volume 25, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the 3 years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state whose AIDS case rate is below 10 or more such cases per 100,000 and meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

¹⁶ <http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf>

¹⁷ SAMHSA will provide each state with information regarding the projected number and demographics of potentially uninsured individuals.

4. Services for individuals in need of primary substance abuse prevention *

5. In addition to the targeted/required populations and/or services required in statute, states are encouraged to consider the following populations, and/or services:

- Individuals with mental and/or substance use disorders who are homeless or involved in the criminal or juvenile justice systems
- Individuals with mental and/or substance use disorders who live in rural areas
- Underserved racial and ethnic minority and LGBT populations
- Persons with disabilities
- Community populations for environmental prevention activities, including policy changing activities, and behavior change activities to change community, school, family and business norms through laws, policy and guidelines and enforcement.
- Community settings for universal, selective and indicated prevention interventions, including hard-to-reach communities and “late” adopters of prevention strategies

States should undertake a broader approach to their assessment and planning process and include other individuals who are in need of behavioral health services. In particular, states should be planning for individuals with incomes below 400 percent Federal Poverty Level (FPL) who are currently uninsured but may be eligible for coverage by Medicaid or private insurance and subsidies to help with the cost of such insurance. This planning will present new opportunities for public behavioral health systems to expand access and capacity. In addition, states should identify how to use federal funds to support the individuals and services that are not covered by insurance and need treatments and supports.¹⁷

MHPAEA, other legislation that enhances access to Medicaid, and SAMHSA’s Strategic Initiatives

17

place an emphasis on identifying the health, behavioral health, and long-term care needs of individuals with mental and substance use disorders. These laws and initiatives also present significant opportunities for states to include in their benefit design recovery support services for adults, youth, and families who have behavioral health needs. In addition, policy drivers place a heavy emphasis on wellness and the prevention of mental, emotional, addiction, and other behavioral disorders. These major themes are relevant for SSAs and SMHAs.

In addition, states should consider linking their *Olmstead* planning work in the block grant application, identifying individuals who are needlessly institutionalized or at risk of institutionalization. There is a need generally for data that will help the state address housing and related issues in their planning efforts. To the extent that such data is available in a state's *Olmstead* Plan, it should be used for block grant application purposes.

B. Planning Steps

For each of the populations and common areas, states should follow the planning steps outlined below:

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

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

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

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

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more 18

comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

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

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

Through the Healthy People Initiative¹⁸ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁸ <http://www.healthypeople.gov/2020/default.aspx>

Step 3: Prioritize state planning activities

Using the information in Step 2, states should identify specific priorities that will be included in the MHBG and SABG. The priorities must include the core federal goals and aims of the MH/SA Block Grant programs: **target populations** (those that are required in legislation and regulation for each block grant) and **other priority populations** described in this document. States should list the priorities for the plan in Plan Table 1 and indicate the priority type (i.e., substance abuse prevention (SAP), substance abuse treatment (SAT), or mental health services (MHS)).

Step 4: Develop goals, objectives, performance indicators and strategies

For each of the priorities identified in Step 3, states should identify the relevant goals, measurable objectives, at least one-performance indicator for each objective, for the next two years.

For each objective, the state should describe the specific strategy that will be used to achieve the objective. These strategies may include developing and implementing various service-specific changes to address the needs of specific populations, substance abuse prevention activities, improving emotional health and prevention of mental illness, and system improvements that will address the objective. Strategies to consider and address include: 19

- Strategies that are targeted for children and youth with SED or substance use disorders. States should use a system of care approach that has been well established for children with SED and co-occurring substance use disorders. This approach should be used state wide, coordinating care with other state agencies (e.g., schools, child welfare, juvenile justice, primary care, etc.) to deliver evidence-based treatments and supports through a family-driven, youth-guided, culturally competent, individualized treatment plan. For adolescents with substance use disorders and SED, this approach should be used in conjunction with evidence-based interventions for substance use or dependence.
- Strategies targeted for adults with serious M/SUDs that will identify and intervene early, connect with, or provide the best possible treatment, and design and implement recovery-oriented services.
- Strategies that will promote integration and inclusion into the community. This includes housing models that integrate individuals into the community instead of long-term care facilities or nursing homes and other settings that fail to promote independence and inclusion. This also can include strategies to promote competitive and evidenced-based supported employment in the community, rather than segregated programs.
- Strategies on how technology, especially integrated co-occurring treatments (ICTs) will be used to engage individuals and their families into treatment and recovery supports. Almost 40 percent of uninsured individuals are under the age of 30 and use technology (internet or texting) as a substantial, if not primary, mode of communication.
- Strategies that result in developing recovery support services, e.g., permanent housing and supportive employment or education for persons with mental and substance use disorders. This includes how local authorities will be engaged to increase the availability of housing, employment, and educational opportunities, and how the state will develop services that will wrap around these individuals to obtain and maintain safe and affordable housing, employment, and/or education.
- Strategies that will increase the availability of screening, brief intervention, referral and treatment (SBIRT). In 2013, SAMHSA brought SBIRT to scale under the SABG. States now have the opportunity to use block grant funds for SBIRT services. However, states should be aware that primary prevention set-aside funds cannot be used to fund SBIRT and should be encouraging the SMAs and Health Insurance Marketplace to include SBIRT as a covered prevention or service-delivery benefit.
- Strategies that will enable the state to document the diversity of its service population and providers and to specify the development of an array of culture-specific interventions and providers to improve access, engagement, quality, and outcomes of services for diverse ethnic and racial minorities and LGBT populations. States will be encouraged to refer to the 2009 IOM report, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*¹⁹ in developing this strategy.

¹⁹ Institute of Medicine. (2009). *Race, Ethnicity, and Language Data: Standardization for Healthcare quality Improvement*. 20

Subcommittee on Standardization Collection of Race/Ethnicity Data for Healthcare Quality Improvement, Board on Healthcare Services. Cheryl Ulmer, Bernadette McFadden, and David R. Nerenz, Editors, Washington, DC: The National Academies Press 20 National Research Council and Institute of Medicine. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC

- Strategies that will build the state and provider capacity to provide evidence-based, trauma-specific interventions in the context of a trauma-informed delivery system. Recognizing trauma as a critical factor in the development of mental and substance use disorders, states should build provider competence in using effective trauma treatments. States should ensure that these treatments are provided in systems that understand the impact of trauma on their service population and work to eliminate organizational practices and policies that may cause new or exacerbate existing trauma. SAMHSA has developed “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach” to provide states with a framework for incorporation of trauma informed care into its system.

Strategies that increase the use of person-centered planning, self-direction, and participant-directed care. This includes measures to help individuals or caregivers (when appropriate) identify and access services and supports that reinforce recovery or resilience. These strategies should also include how individuals or caregivers have access to supports to facilitate participant direction, including the ability to exercise budget and employer authority by managing a flexible budget to address recovery goals; identifying, selecting hiring and managing support workers and providers; and ability to purchase goods and services identified in the recovery or resilience planning process.

- Strategies that are developed to prevent substance abuse and mental disorders and promote emotional health and prevention of mental illness should be consistent with the latest research, including the 2009 IOM report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*.²⁰ This report articulates the current scientific understanding of the prevention of mental and substance use disorders. It also describes a set of interventions that have proven effective in preventing substance abuse and mental illness, promoting positive emotional health by addressing risk factors, and promoting protective factors related to these problems. States should identify strategies for the SABG that reflect the priorities identified from the needs assessment process, including:

- As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies and practices in their prevention efforts that include:

- Information dissemination;
- Education;
- Alternatives that decrease alcohol, tobacco, and other drug use;
- Problem identification and referral;
- Community based programming; and,
- Environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population.

- Prevention strategies should also be consistent with the IOM *Report on Preventing Mental*

Emotional and Behavioral Disorders, the Surgeon General's *Call to Action to Prevent and Reduce Underage Drinking*²¹, the National Registry of Evidenced-based Programs and Practices (NREPP), and/or other materials documenting their effectiveness. These strategies include:

- Strategies that target tobacco use prevention and tobacco-free facilities, which are supported by research and encompass a range of activities including policy initiatives and programs.
- Strategies that engage schools, workplaces, and communities to establish programs and policies to improve knowledge about alcohol and other drug problems, denote effective ways to address the problems, and enhance resiliency.
- Strategies that address underage drinking based in science and encompass a range of connected activities including policy and regulation, enforcement, and normative/behavior change initiatives and programs.
- Strategies that implement evidence-based and cost-effective models to prevent substance abuse in young people in a variety of community settings, e.g., families, schools, workplaces, and faith-based institutions, consistent with the current science.
- Strategies that follow the Surgeon General's *Call to Action to Prevention and Reduce Underage Drinking*, developed in coordination with the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD), that focus on policy and environmental programming to change the community's norms around, and parental acceptance of, underage alcohol use.
- Strategies that address harder-to-reach racial/ethnic minority and LGBT communities that experience a cluster of risk factors that make them especially vulnerable to substance use and related problems.

²¹ <http://store.samhsa.gov/product/Surgeon-General-s-Call-to-Action-to-Prevent-and-Reduce-Underage-Drinking/SGCTA-07>

- States should identify strategies for the MHBG that reflect the priorities identified from the needs assessment process. Strategies that are focused on emotional health and the prevention of mental illnesses should be consistent with the IOM report on *Preventing Mental, Emotional, and Behavioral Disorders Among Young People* and should include:
 - Strategies that work with schools, workplaces, and communities to deliver programs to improve mental health literacy and enhance resilience.
 - Strategies that target prevention and early intervention programs for children and their families through partnerships between mental health, maternal and child health services, schools, and other related organizations, and to include evidence-based and cost-effective models of intervention for early psychosis in young people.
 - Strategies that implement suicide prevention activities to identify youth at risk of suicide and improve the effectiveness of services and support available to them, including educating frontline workers in health, and other social services settings about mental health and suicide prevention.
 - Strategies that implement evidenced-based interventions and trauma-specific treatments for highly vulnerable children and young people who have experienced physical, sexual, or emotional abuse, bullying, and/or other trauma, with a separate focus on youth from tribal, racial/ethnic minority, and LGBT communities.
 - Strategies that follow the Surgeon General's *National Strategy for Suicide Prevention*, including promoting the awareness that suicide is a public health problem that is preventable and implementing community-based suicide prevention programs.

- Strategies that identify evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders.^{22 23}

²²http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

²³ www.samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

- System improvement activities may be included as a strategy to address issues identified in the needs assessment. System improvement activities should:
 - Allow states to position their providers to increase access, retention, adoption, or adaptation of EHRs, or to develop strategies to increase workforce numbers. These system improvement activities should use federal and state resources currently available and those proposed for the planning period to enhance the competency of the behavioral health workforce. System improvements that seek to expand the workforce should build upon existing efforts to increase the role of people in recovery from mental and substance use disorders in the planning and delivery of services.
 - Support providers to participate in networks that may be established through managed care or administrative service organizations (including ACOs). This may include assistance to develop the necessary infrastructure (e.g., electronic billing and EHRs) and reporting requirements to participate in these networks.
 - Encourage the use of peer specialists or recovery coaches to provide needed recovery support services, which are already delivered by volunteers and paid staff. Peers are trained, supervised, and regarded as staff and operate out of a community-based or recovery organization. A state's strategy should allow states to support peer and other recovery support services delivered under either model. The infrastructure, including paid staff, to coordinate and encourage the use of volunteer- delivered or run services should also be supported.
 - Increase links between primary, specialty, emergency and rehabilitative care and behavioral health providers working with behavioral health provider organizations for expertise, collaboration, and referral arrangements, including the support of practitioner efforts to screen patients for mental and substance use disorders. Activities should also focus on developing model contract templates for reciprocal health and behavioral health integration and identifying state policies that present barriers to reimbursement. This would include efforts to implement health homes (§2703 of the Affordable Care Act), dual eligible products, ACOs, and medical homes.
 - Develop support systems to provide communities with necessary needs assessment information, planning, technical assistance, evaluation expertise, and other resources to foster the development of comprehensive community plans to improve mental, emotional, and behavioral health outcomes.
 - Fund auxiliary aids and services to allow people with disabilities to benefit from the mental health and substance use services and language assistance services for people who experience communication barriers to access.
 - Develop benefit management strategies for high-cost services (e.g., youth out of home services and adult residential services). SAMHSA believes that states should align their care management to guarantee that individuals get the right service at the right time in the right amount. These efforts should ensure that decisions made regarding these services are clinically sound. SAMHSA will expect states to develop spending targets for certain services and

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manage within those targets.

2016 BLOCK GRANT PRIORITY POPULATIONS AND STRATEGIES

INTRODUCTION:

- **Amounts**

- Mental Health Block Grant \$1,634,828
- Substance Abuse Block Grant \$7,478,729

- **Set Asides and MOEs**

- Primary Prevention at least 20% of SABG
- Children's Mental Health at least 10% of MHBG
- Women's Maintenance of Effort state and federal, no less than \$ 1,964,739

- **Disconnect with State Budgeting Process**

- **SAMHSA's Vision for BG Planning Process**

Block Grant Programs' Goals

SAMHSA's SABG and MHBG are designed to provide states with the flexibility to design and implement activities and services to address the complex needs of individuals, families, and communities impacted by mental disorders and substance use disorders. The goals of the block grant programs are consistent with SAMHSA's vision for a high-quality, self-directed, and satisfying life.

Key SAMHSA Assumptions

States should be strategic in their efforts to purchase services.

States should leverage their block grant funding and strive to diversify funding sources.

States should think more broadly than the populations they have historically served through federal block grants and other funding.

States should design and develop collaborative plans for health information systems. Health care payers will seek to promote EHR and interoperable information technology systems that allow for the effective exchange and use of health data.

States may form strategic partnerships to provide individuals with access to effective and efficient services systems.

State authorities should focus on recovery from mental health and substance use problems.

State authorities should monitor the coverage of behavioral health services offered by QHPs and Medicaid to ensure that individuals with behavioral health conditions have adequate coverage and access to services.

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State authorities should be strategic in leveraging scarce resources to fund prevention services

State authorities should monitor the Marketplace to ensure that individuals with behavioral health conditions are aware of their eligibility, able to enroll, and able to remain enrolled.

State authorities should make every effort to ensure that the right recipient is receiving the right payment for the right reason at the right time.

State authorities should use evidence of improved performance and outcomes to support their funding and purchasing decisions. State authorities should ensure that they comport with changes in quality reporting.

States authorities should monitor compliance with the federal parity law to ensure that individuals with behavioral health conditions are receiving the mandated coverage and access.

State authorities should be key players in behavioral health integration activities.

Population changes in many states have created a demographic imperative to focus on improving behavioral health prevention, care, and recovery for diverse racial, ethnic, and LGBT populations with the goal of reducing disparities.

State authorities are encouraged to implement, track, and monitor recovery-oriented, quality behavioral health services.

State authorities should ensure that their states have a system of care approach to children's and adolescents' behavioral health services.

- **SAMHSA Required and Suggested Priority Populations**

Required Federal Priority Populations and State Priority Populations: *Sections in black are required. Sections in red are not, but we can consider. Some have been deleted that were not required that we did not think we had data to support.*

1. Comprehensive community-based mental health services for adults with SMI and children with SED:

- * Children with SED and their families **Ranny**
- * Adults with SMI **Jim**
- * Older Adults with SMI **Jim**
- * Individuals with SMI or SED in the rural and homeless populations, as applicable **Jim**

2. Services for persons with or at risk of having substance use and/or SMI/SED:

- * Persons who are intravenous drug users (IVDA)
- * Adolescents with substance abuse and/or mental health problems (Transition age Youth/young adults) **Jim**
- Children and youth who are at risk for mental, emotional, and behavioral disorders, including, but not limited to, addiction, conduct disorder, and depression **Not decided whether to do this (DCYF)**
- * Women who are pregnant and have a substance use and/or mental disorder
- * Parents with substance use and/or mental disorders who have dependent children
- * **Military personnel (active, guard, reserve, veteran) and their families**
- * **American Indians (prescription drug use 20%)**
- **X Unaccompanied minor youth**

3. Services for persons with or at risk of contracting communicable diseases:

- * Individuals with tuberculosis and other communicable diseases
- **X Persons living with or at risk for HIV/AIDS and who are in need of mental health or substance abuse early intervention, treatment, or prevention services **We do not need to respond to this section – state doesn't have enough incidence of HIV to meet federal requirements for response.****

4. Services for individuals in need of primary substance abuse prevention *

-
- **5. In addition to the targeted/required populations and/or services required in statute, states are encouraged to consider the following populations, and/or services:**
- **X Individuals with mental and/or substance use disorders who are homeless or involved in the criminal or juvenile justice systems **covered under Homeless SMI****
- **X Individuals with mental and/or substance use disorders who live in rural areas**
- * Underserved racial and ethnic minority and LGBT populations
- **X Persons with disabilities**
- * Community populations for environmental prevention activities, including policy changing activities, and behavior change activities to change community, school, family and business norms through laws, policy and guidelines and enforcement.
- * Community settings for universal, selective and indicated prevention interventions, including hard-to-reach communities and “late” adopters of prevention strategies

2016 BG PLANNING

- **2016 Priority Populations, Strategies and Objectives:**

- **1. Mental Health Services for SMI and SED**

- Children with SED (in progress/DCYF)

- Adults with SMI
 - Objective: reduce over use of hospital beds
 - Goal: reduce hospitalization, re-hospitalization and length of stays
 - Strategy: Increase peer supports in Respect program
 - Indicator: Number of clients diverted and stepped down from hospital admissions that are served through the Respect program

- Older adults with SMI
 - Objective: increase access to behavioral health services
 - Goal: increased collaboration with DEA, OHHS to understand and begin addressing problems with access to services
 - Strategies: BHDDH convene meetings and focus groups with DEA, OHHS, RIEMHAC to assess needs, prioritize needs, develop action plans
 - Indicator: Number of meetings w/action plans

- SMI and SED who are homeless
 - Objective 1: Increase access to medical insurance and SSI/SSDI for homeless SMI
 - Goal: increased numbers of SMI homeless to enroll in SSI/SSDI and Medicaid
 - Strategies: increase the number of successful SOAR and Medicaid applications by providing SOAR services and Medicaid enrollment assistance through the PATH contract
 - Indicator: number of successful applications for SSI/SSDI and Medicaid

 - Objective 2: Increase statewide availability of homeless outreach
 - Goal: provide coordinated statewide outreach
 - Strategies: use PATH grant to develop statewide, coordinated network of local outreach
 - Indicator: geographical distribution of outreach activities

 - Objective 3: Increase participation of homeless SMI in behavioral health services beyond initial screening/assessment
 - Goal: more homeless will receive behavioral health services

- Strategies: use PATH grant to: provide more intensive street-based BH services, provide intensive case management that will increase follow-through on BH and health service referrals, provide more BH services in day program for homeless
 - Indicator: numbers of BH services provided as recorded in HMIS system
- **2. Persons having or at risk for SUD/SMI**
 - IVDU
 - Adolescents with SA and/or MH problems
 - Objective 1: increase access of transition-aged youth/young adults to behavioral healthcare services
 - Goal: more youth/young adults receive MH/SUD treatment
 - Strategy 1: implement Healthy Transitions grant
 - Indicator: number receiving services through HT grant
 - Objective 2: increase the number of youth/young adults engaged in HT governance and as peer supports
 - Goal: more youth/young adults participate in HT and other meetings, including Rally for Recovery
 - Strategy 1: use TA and work w/youth programs to increase youth participation
 - Indicator: numbers participating in meetings, in particular Rally for Recovery
 - Strategy 2: develop youth/young adult peer support curriculum w/certification
 - Indicator: number certified as peer support providers
 - Children and youth at risk (in progress/DCYF)
 - Pregnant women and women dependent children w/SUD
 - Objective: ensure that all licensed BH providers meet BG requirements for services to PW/WDC
 - Goal 1: BG requirements for PW/WDC incorporated in all contracts for women's services (BHDDH and OHHS)
 - Strategy 1: review all BHDDH contracts that serve PW/WDC, add language re: BG requirements, including trauma-informed care
 - Strategy 2: work w/OHHS to add language to MCO contract requirements

- **Connecting the BG Planning Process to the State Budgeting Process**

- BG Grant Funding History
- Need to begin planning in 9/15 for FY 2017 BG uses

SABG Requirements for Women’s Treatment Services (Pregnant women and women with dependent children who are abusing substances)

1. The implementing regulation **requires** the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.

**MEETING MINUTES FOR THE
GOVERNOR'S COUNCIL ON BEHAVIORAL HEALTH
TUESDAY, MAY 12, 2015**

Members present: Richard Leclerc (Chair), Chaz Gross, Joseph Le, Cheryl Patinaude, Bruce Long, Anne Mulready, Cherie Cruz, Sarah Dinklage, Richard Antonelli

Appointed members present: David Spencer (DATA of RI) & Megan Clingham (MHA)

Statutory members present: none

Ex-officio members present: Colleen Poselli (DOH); Ray Neirinckx (OHCD); Sharon Kernan, Rebecca Plonsky, Jessica Mowry (EOHHS); Linda Mahoney, Bette Ann McHugh, Anna Meehan, Linda Barovier (BHDDH; Ruth Anne Dougherty, Chris Strnad, Colleen Caron (DCYF); Lou Cerbo (DOC); Alice Woods, Denise Achin (RIDE/RITAP), (EOHHS); MaryAnn Ciano (DEA)

Guests: Brian Sullivan (Operation Stand Down RI); Elizabeth Conley, Thomas Joyce (TPC/Anchor), Shannon Spurlock (JSI); Lisa Conlan (PSNRI); Liz Buddington (RICARES)

Staff: Linda Harr, Jim Dealy

Review of minutes (Rich Leclerc): A quorum being present, the meeting was called to order. Several members requested changes to the Minutes of April 9, 2015. The Minutes were approved pending the suggested revisions. Those changes have been made and added to the Amended Minutes to be forwarded to the Committee by Jim Dealy.

Linda requested that, when possible, members notify either Jim or her prior to the meeting of any requests for changes to the previous minutes.

Subcommittee Reports: (Shannon Spurlock) On behalf of Sandra Delsesto and the PAC Committee Shannon requested that the Governor’s Council forward a letter to the Governor and to the Legislature requesting that a line item be added to the budget for not less than \$63,250.00 to allow for meeting enforcement requirements for the Synar grant. A Council member asked whether Rhode Island is currently in compliance with the Synar requirements. The response was that we have until September 30, 2015 to meet the enforcement requirements, which will allow us to continue to qualify for the Synar grant. Going forward, we will need funding in order to be meet the enforcement requirements each year. Rich advised the letter would be sent forthwith.

DCYF CANS (Child and Adolescent Needs and Strengths) Report (Colleen Caron):

Copies of the report entitled “**Child and Adolescent Needs and Strengths (CANS) Summary Scores for the Initial Assessment by Placement Type: July 2013-January 2015**” were distributed.

The information from this report is basically on two levels – on an individual level and on the aggregate level. From aggregate level data, an algorithm is being developed to help determine whether children/youth are receiving the correct level of care. That use of the CANS is in the future. The data being presented today is more on a surveillance level from the initial CANS.

The report covered the following:

Current placement in Rhode Island: The majority of those children/youth in placement are in in specialized foster care, group homes and residential, with a small portion in home/foster care and independent living. As to **gender**, there are approximately 72% male and 28% female. Regarding **Race/Ethnicity**, the population is 44% white, 17% African American, 19% Hispanic with the remaining 20% being either other or missing. The mean **age of treatment** is 18 years of age, with a range from 4.5 -18+ years of age. The **mean number of actionable items is 5.6**. If you get a rating of 2 or 3 in a particular domain, then it constitutes being an actionable item (something that requires follow-up). The areas of actionable items include such categories as **family i.e.**, (domestic violence, constant arguing), **living situation** (child at risk of removal), **sleep, social and daily functioning, developmental, legal** (probation, juvenile parole), **medical, and daily living**.

The **caregivers report the top three needs** fall within the categories of: Supervision, Social Resources (lack of assistance/family support), and Family Stress (prevents the caregiver from parenting). The **child risk behaviors which makes it impossible for them to remain with their parents** include: Impulsivity/Hyperactivity, Depression, Anxiety, Oppositional, Conduct, Adjustment to Trauma, Anger Control. When asked if the appropriate services were being provided by the substitute caregivers to meet those needs, Colleen responded that they should be. Most of the youth are in group care programs. In addition, the children/youth have case managers available. When looking at the family as a unit, the needs of the caregiver(s) often parallel those of the child(ren) in need. As far as **obtaining independent living placements**, similar issues are seen as **problems**: family, recreation, and legal being among the highest. **Youth who are in specialized foster placement** present with the **emotional needs** of impulsivity/hyperactivity, anxiety, oppositional, and adjustment to trauma. The **child risk behaviors are relatively low in all categories** because the children/youth are in supervised settings. **Emergency shelter placements** show the following to be **high problem areas: family, living situation, social functioning, recreation, judgment, as well as the recurring legal**. This information is being used by DCYF on an individual treatment level for treatment choices, trends, and service decisions as well as with family team meetings.

There are different domains within the assessment. There are also different CANS which assess the different populations, such as juvenile justice, behavioral health, etc. Within the last month, the **trauma module** has been added to this comprehensive care assessment for level of care.

The first part of the report provides a review of the population and then the level of care. The report covers the youth who are “in state.” The youth who are “out of state” are not reflected within the report.

Block Grant planning process (Jim Dealy): The BHDDH/DCYF Block Grant Writing Team began weekly meetings in April. It met with the Council’s Block Grant team this morning. The plan was for the BHDDH/DCYF Team to develop an outline of the problems and priorities identified to go into the BG Application by July 1st, so that the GC team will have time to review and make suggestions for the Application.

Update from DCYF: (Chris Strnad): The Family Care Network contracts expire on June 30th and DCYF is assessing the success of the network contracts. The reduction in the numbers of children/youth in residential care which was the goal of the Network contracts has not happened. This is in the context of a considerable increase in the

number of investigations and DCYF intakes, an increase in the number of families involved with DCYF and an increase in the severity of needs within families over the past few years. Currently DCYF has begun discussions with both networks on short-term contract extensions.

Update from BHDDH (Rebecca Boss): Weekly meetings continue to be held on the Medicaid redesign of the system for the BHDDH's adult consumers. There are now two groups – one regarding the funding mechanisms and one regarding the service package. The other area that has been receiving attention is that of grant applications. With the change of leadership we were most fortunate to have Michelle Brophy redirected to Behavioral Health and the DD world bringing her skills and talents to us. June 6th there will be a training held by Dr. Paul Seal who is coming in address healthcare providers on opioid use. There are three areas of address for the Mental Health Summit which include behavioral health, the opioid crisis and the incarceration of individuals with behavioral health issues. Information will be forthcoming on the date. The Overdose Task Force continues to meet on a monthly basis.

Michelle Brophy: Michelle stated that the first thing she did was to apply for the Collaborative Agreement to Benefit Homeless Individuals (CABHI). It would be a three year grant for 5.5 million dollars to address homelessness in the state for people with mental health and substance abuse issues. If we get that it would greatly supplement the grant we received last year. BHDDH and DOC are also applying for the Offender Re-entry Program Grant that will be submitted on May 22nd. Work is continuing done on the Block Grant

Update from EOHHS (Sharon Kernan): EOHHS has been busy supporting the work of the Reinventing Medicaid workgroups that have been established. The Governor has put together a set of initiatives that have now been presented to the General Assembly in the form of proposals. EOHHS will be monitoring that and once the General Assembly has concluded its review, EOHHS will move forward to implement those initiatives. They are grouped into three themes: payment and delivery system reform, targeting fraud waste and abuse, and administrative and operational efficiencies. This does include some potential rate cuts to hospitals and nursing homes with some incentive programs especially for hospitals. There will also be efforts to develop more systems in managed care, behavioral health, and other areas.

A board member requested a presentation on how these reductions will be accomplished. Sharon said that such a presentation would be premature at this point.

Old/New Business: Notices were provided for a free dental clinic at CCRI.

The meeting was adjourned by vote of the members.

Next Meeting: Thursday, June 11, 2015, 8:30 A.M.

Barry Hall

Conference Room 126

14 Harrington Road, Cranston, RI 02920

Statutory and Public members, please let Jim Dealy know if you cannot attend

This meeting is open to the public.

If you plan to attend and you require special accommodations to ensure equal participation, please contact Jim Dealy at the Division of Behavioral Healthcare Services at 462-0118.

**MEETING MINUTES FOR THE
GOVERNOR'S COUNCIL ON BEHAVIORAL HEALTH
TUESDAY, JULY 14, 2015**

Public Members present: Mark Fields, Joseph Le, Richard Leclerc, Anne Mulready, Sarah Dinklage

Appointed members present: David Spencer (CEO of DATA of RI) and Megan Clingham (Mental Health Advocate)

Statutory members present: none

Ex-officio members present: Ruth Anne Dougherty, Chris Strnad (DCYF); Lou Cerbo (DOC); Alice Woods (RIDE); Colleen Poselli, Jeffrey Hill (DOH); Rebecca Boss, Michelle Brophy, Anna Meehan, Judy Fox, Linda Barovier (BHDDH);

Guests: Lisa Tomasso, Michael Esposito (TPC/Anchor); Lisa Conlan (PSNRI); Diane Dufresne (Pawtucket Prevention Coalition); David Martins (RICARES); Rachel Plummer (DOH intern)

Staff: Jim Dealy; Oyediya Ezikpe (BHDDH legal intern)

Review of minutes (Rich Leclerc): A Motion was made, carried and the Minutes were accepted as presented.

Healthy Transitions Committee (Anne Mulready): This Committee is the Healthy Transition program's state advisory body and a subcommittee of the Council. It grew out of the Council's Transitioning Youth Committee of four-five years ago. It meets on the 2nd Tuesday of each month and the next meeting is August 11th from 3-4:30pm. We participated in a two-day SAMHSA site visit at the Kent Center that focused best practices for the youth/young adult population on the youth and how to develop peer supports among youths along with a youth driven approach to services. The Subcommittee is looking forward to increasing our diversity and figuring out ways to connect with youth. Once the Youth Coordinator is hired, the Committee will probably be strategizing about different meeting times and locations so as to involve more young people. There is a grant meeting coming up in Maryland on August 4th-6th. Sherry Cruz will be attending and representing a family member of a young adult.

Prevention Committee (Sandra Delsesto): Scheduled for next meeting.

Block Grant planning update (Jim Dealy): Jim went over the basics of the Block Grant, what the requirements are and what directions the planning was going in. The Block Grant is due on September 1st. The writing team is Ranny Dougherty, Jim Dealy, Betsy Kretchman and Linda Mahoney and has involved other people as needed. Last year's Mental Health Block Grant was \$1.6 million, and the Substance Abuse Block Grant was almost \$7.5 million. The Block Grants are not meant to substitute for other funding, like Medicaid or state funds, but are meant to stimulate improvements in states' systems.

Some uses for the Block Grant are required. Primary Prevention has to get at least 20% of the Substance Abuse Block Grant. Children's Mental Health is required to get at least 10% of the Mental Health Block Grant. 5% must be set aside to treat early incidence of Severe Mental Illness (SMI). We are using that to enhance the services through the Health Transitions grant. Women's services is one of the core focus areas of the Substance Abuse Block Grant, and the state is not allowed to spend less than \$1.9 million per year on Women's services.

One of the big problems in the planning process over the years is the disconnect between the state budgeting cycle and the Block Grant budgeting cycle. The Block Grant is awarded on October 1st, by which time the state has already finalized a budget, and the contracts that draw on the Block Grant have already been awarded. This means that all the Block Grant funds for FY 2016, the year that we are currently writing the Block Grant for, have already been awarded. To change how we will spend the Block Grant for FY 2017, we will have to start in September and have pretty firm plans by January, which is when the state starts putting together its budget. BHDDH and DCYF are hoping to get good participation from the Governor's Council in this planning, starting in September. What SAMHSA's block grant is designed for is all laid out on the handout.

Jim went over a number of things that SAMHSA is asking states to focus on in this year's application. These include:

- Changes in the way states plan and fund behavioral health services. For example, in RI, the behavioral health services budget which was administered by BHDDH is now administered by EOHHS, much of it through Managed Care Organizations. This raises questions about what BHDDH's role will be in behavioral health planning.

- Being sure that states purchase services in a way that leads to good outcomes and that doesn't substitute for state or Medicaid funds.
- Broadening the focus of their behavioral health services, especially to include racial and ethnic minorities and LGBT individuals, homeless, the elderly and transitioning youth. SAMHSA is urging states to look at behavioral health needs over the lifespan of individuals, rather than to treat behavioral health conditions in silos according to age or diagnoses.

Jim went over the populations that SAMHSA is requiring states to use the Block Grant for and those additional groups that Rhode Island has chosen to serve. Jim will email his handout with these minutes.

Mental Health Summit (Michelle Brophy):

The Mental Health Summit occurred on June 8th with an attendance of over 300. Three questions were asked to basically set the stage and get community feedback on how we can change the system to address the three issues mentioned. Opiate addiction and the overdose epidemic were talked about, as were the connections between behavioral health and corrections and the integration of Behavioral Health and Mental Health. The PowerPoints that were used in the Summit as well as the minutes are posted on BHDDH's website. Action steps will be posted on the website in late July that talk about what the department will be doing with the information gathered at the summit and an implementation plan will be developed. In September/October there will be a Mental Health Children's Summit and DCYF will be taking the lead in planning that.

Members asked that the Council be part of helping to develop the implementation Plan for the Mental Health Summit. They also asked that members of the Transition Committee be part of the Children's Mental Health Summit, since those who are transitioning from the children's to the adult systems have such significant needs. A letter will be sent to the Secretary's office stating that the Governor's Council wants to be involved in creating the implementation plan for both Summits.

Information on the Mental Health Summit can be found at:
<http://www.bhddh.ri.gov/events/event/event.php>

The Council's letter will be attached to these minutes.

Legislative representation (Rich Leclerc): The plan for getting the legislative representation which is required by state law was discussed in terms of whether it was better to approach possible candidates directly, or through the Speaker and Senate. A formal letter to the Speaker of the House has been tried but only received a polite response in return. However, Representative Matiello has not been asked since he became Speaker, so Rich will send a letter sent to his secretary asking for a brief meeting with him to explain the Council's needs.

Update from DCYF (Chris Strnad): DCYF has resolved some of the issues around its present contracts. It have now signed six-month extensions for the two Network contracts. In addition, other contracts, including that with PSN, which was discussed at the last Council meeting, have been extended for three months.

DCYF continues to look at ways to make its contracts lead to better program outcomes. There is now a requirement in the Network and FCCP contracts that the providers use CANS (Child & Adolescents Needs and Strengths), a functional assessment tool for planning and to know where kids are and whether or not they are going to the right level of care and that they have 95-100% compliance with CANS scores. DCYF has also been working with the Governor's Performance Lab to look at performance based contracts. It is also to meeting with many of its providers to talk about how they are being paid, what it is getting out of their services and whether they are passing performance expectations.

The out-of-state placements number is in the low 80s. It has trended up in the past 3 years, but has leveled out for the past 6-8 months. There is a need to increase in-state capacity for housing of the youth. However, keeping kids in state should not be used as a cost saving method. DCYF hopes to focus the system on much earlier preventive and early intervention sooner to prevent hospitalization. There is no change on the policies for voluntaries and custodies, but more details have been added to the policy which currently existst. Kids currently at Arcadia will be sent home, put in foster care, or sent to other facilities.

Update from BHDDH (Linda Mahoney): Towards the end of the week of July 13th, the final results from the Truvan Study will be released. The study, created by the HICPAC Committee, takes a comprehensive look at the need, cost, and capacity of Behavioral Healthcare system across age groups, which include children and adults. BHDDH will keep everyone posted on that. The Department has also been working with EOHHS and other state agency partners in the implementation of the SIM (State

Innovation Model) Grant and BHDDH's position on the grant will be posted shortly. There will soon be news on the Governor's Overdose Task Force. On another topic, staff from BHDDH have met with EOHHS and talked about health plan benefits meeting the needs of consumers. One issue is the reduced access to adequate levels of in-patient residential substance abuse treatment as these services into managed care plans. BHDDH has received a SAMHSA CABHI Grant Cooperative Agreement for 3 years for \$5 million which benefits homeless individuals, resulting in eventually ending chronic homelessness. Reminder that the Rally for Recovery is September 19th. The Prevention Advisory Committee is meeting on July 30th. The State Epidemiology Profile is in draft and soon will be ready for this group to look at.

Update from EOHHS (Deb Florio): Put on agenda for next meeting.

Old/New Business (Rich Leclerc): None.

The meeting was adjourned by vote of the members.

Next Meeting: Thursday, August 13, 2015, 8:30 A.M.

Barry Hall

Conference Room 126

14 Harrington Road, Cranston, RI 02920

Statutory and Public members, please let Jim Dealy know if you cannot attend

This meeting is open to the public.

If you plan to attend and you require special accommodations to ensure equal participation, please contact Jim Dealy at the Division of Behavioral Healthcare Services at 462-0118.

4/2015 Governor's Council Block Grant Planning Team

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Rich Leclerc rleclerc@Lifespan.org

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Chaz Gross chaznami@cox.net

David Spencer dspencer@dataofri.org

Alice Woods alice.woods@ride.ri.gov

Allision Theriault a.theriault@psnri.org

BG Writing Team Notes

5/12/15

- Met with David Spencer, Chaz Gross from Governor's Council Block Grant Committee
- Identified some system gaps: decided to have Writing Team draft Step 2, then bring to GC BGC
 - o Adolescent SA residential treatment beds
 - o Lack of referrals for ASART
 - o Over reliance on residential care for children/lack of confidence in community-based EBPs
 - o Need for enhanced group rates
- The proposed BG expenditures were explained
- Determined priority populations (Step 3)

GOVERNOR'S COUNCIL ON BEHAVIORAL HEALTH

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8/27/15

To the Substance Abuse and Mental Health Services Administration:

This letter is to confirm that The Rhode Island Governor's Council on Behavioral Health, which is the state's Behavioral Health Advisory Council, has reviewed the 2016 Combined Block Grant Application. The Council members recommended language that would clarify and correct the draft Application, which the state will incorporate into the Application. In addition, Council members will submit comments to be included as part of the Application.

A particular focus of the Council was the set of ten recommendations for future uses of the Block which it developed in 2014. These recommendations are in the 2016 Application on page two of Step two. In order of priority, they are:

- Services to transitional age youth (ages 16-25)
- Capacity for needs assessment, performance and outcome data analysis
- Parent support programs
- Supplemental funding for children's EBP services that are not fully covered by insurers, including Medicaid MCOs
- Expansion of student assistance program capacity for interventions like SBIRT
- Services for veterans who are not eligible for Tri-Care
- Peer support services
- Behavioral healthcare workforce development
- Respite services
- Adolescent suicide prevention
- Anchor Recovery Centers

Some of these items have received funding in SFY 2015 and 2016, either through the Block Grant or through discretionary grants. The Council hopes to enhance these programs over the course of the next year. The Council has agreed to work closely with BHDDH and DCYF as they begin, starting next month, to plan for the 2017 Block Grant.

Sincerely,

Richard Leclerc
Chairperson, Rhode Island Governor's Council on Behavioral Health

Public Comments on the 2016 Block Grant Application for Rhode Island

Comments from meeting to discuss the Draft of the 2016 SA and MH Block Grant Application for the Governor's Council on Behavioral Health

Meeting held in Barry 126 on Tuesday, August 26, 2015 from 3:00 to 4:30 pm

Attendees: Rich Leclerc (Chair), Rosemary Petteruti (staff), Colleen Polselli, Mehan Clingham, Anne Mulready, Lisa Conlan, George O'Tolle, Brian Sullivan, Ranny Dougherty, Jim Dealy (staff), Mark Field, Michelle Brophy, Cherie Cruz, Jim McNulty, Sandra Delsesto, Lisa Tomasso

Comments and suggestions on the proposed draft:

- Rich suggested that an advisory letter be written. There should be some input for the understanding of the allocation of dollars. There is an understanding that the need is greater than the funds.
- Ann asked if the report is made public.
- Discussion over where the term 'co-single SSA' came from. The term comes from SAMHSA. It was stated that the correct term to be used is 'co-Single State Agency'.
- Are we able to get more data from NHP (MCO for Medicaid Expansion and other Medicaid populations) and other places?
- The Council has a list of priorities. Everyone needs to know what we are/are not funding.
- The MH Block Grant ties in to specific funding. What was implemented?
- Block Grant – there is no report that matches up proposed and actual funding or what amounts of Block Grant funding were received by which providers.
- Michelle Brophy (BHDDH) said that one of the key activities in next year's planning cycle to begin 9/1 is to create a matrix of Block Grant and other funding
- Transitional age youth continue to be important – need to know where the needs are
- Concerns are that to fund a new program, current programs will have to be cut
- The Block Grant planning process is one way to get at priorities
- Re Step 2: needs assessment for the youth treatment planning grant
- Do we use money to build better info structure or for programs? Both are needed.
- We need an executive summary of the Block Grant Application.
- We need to use peers for support services
- Re Veterans: this needs to be looked at for next year. Need more outreach and partnership programs
- Re Critical Gap (under the unmet needs, item 5) – there is something missing before the word "data."
- Adolescent substance abuse treatment beds have decreased. Will there continue be funding for adolescents treatments/residential centers?
- Can money be moved around within the grant once approved?
- Next step: Jim asked for everyone to email him comments by Thursday. He needs written comments by Friday so he can get it in by next Tuesday.

Additional written comments:

“As you know, the Youth Transition Committee of the Governor’s Council is meeting to update the findings and recommendations of its March 2012 report to the Council. One of those findings concerned the Medicaid MCO coverage of outpatient services: “Child and Adolescent Intensive Treatment Services (CAITS) is limited in scope and duration of needed services.” (I believe that CAITS replaced “Children’s Intensive Services,” a Yale School of Medicine evaluated and supported practice – that provided services of longer duration.) As you report in the Block Grant application, one of the Council’s recommendations in 2014 was to look at supplemental funding for children’s EBP services that are not fully covered by insurers including Medicaid MCOs. The discussion of Treatment Options for children in Step 1 of the Block Grant Application mentions Enhanced Outpatient Services, which are offered through Medicaid MCOs. It looked as though two EBF’s for family interventions have been incorporated into the Neighborhood MCO plan. In updating the 2012 Report, I hope that the Youth Transition Committee will be able to update information about the current use of EBF’s in Medicaid MCO plans.”

- Anne Mulready, Governor’s Council on Behavioral Health member

Just a few comments. I'm glad I attended the meeting ---- because----- Wow!! has the Block grant application preparation changed over last few years. Also, Michele (Brophy – BHDDH administrator for planning) stating that we should begin next year’s Block Grants needs around this Sept or Oct is point-on. Next grant-----If additional funding could be added to the children's programs/services (even if just a small amount) it would be a great help and boost to the at-large children's needs. My friend-- this Block Grant and the monthly Governor's Council meetings surely benefit by your involvement.

- Mark Fields, Governor’s Council on Behavioral Health member

**MEETING MINUTES FOR THE
GOVERNOR'S COUNCIL ON BEHAVIORAL HEALTH
THURSDAY, AUGUST 13, 2015**

Members present: Richard Leclerc (Chair), Mark Fields, Bruce Long, Maxine Heywood, Cherie Cruz, Sarah Dinklage, Brian Sullivan

Appointed members present: none

Statutory members present: none

Ex-officio members present: Ruth Anne Dougherty, Chris Strnad (DCYF); Colleen Polselli, Jeffrey Hill (DOH); Ray Neirinckx (OHCD); Sharon Kernan (EOHHS); Denise Achin (RIDE/RITAP); Mary Ann Ciano (DEA); and Lou Cerbo (DOC).

Guests: Lisa Tomasso, George O'Toole (TPC/Anchor); Christopher Mahon (Providence Center School/ALA); August Eddleilson (RIPRC); D. Martins (RI Cares); Rachel Plummer (RI HOD intern)

Staff: Jim Dealy, Oyediya Ezikpe

Review of minutes (Rich Leclerc): A quorum being present, the meeting was called to order. Minutes were approved pending the suggested revisions. Those changes have been made and added to the Amended Minutes to be forwarded to the Committee by Jim Dealy.

Prevention Committee (Sandra Delsesto): Most of the focus at the last Prevention Advisory Committee meeting was on Synar. Contracts are currently being issued to police departments. Thanks to the support of the Governor's Council, the legislature has allocated money for Synar. The Block Grant supplements state funds but is not sufficient. \$60,000 is required for SYNAR Compliance. \$12,000 comes out of the Block Grant but it is specific to compliance checks only, and cannot fund legal time, court time for the police officers and time for filing the reports. Therefore, \$48,000 is required in state funds, and this has now been allocated by the Legislature.

The Violation rate (the rate of tobacco purchases by minors) has increased from 10% to 12%. If they go above 15%, it puts the 40% of the Substance Abuse Prevention and Treatment Block Grant in jeopardy. A big problem lies with the use of ENDS (Electronic

Nicotine Delivery Systems). State law does not consider them to be “tobacco products,” but federal law does. Legislation went to the General Assembly for Child Protective Packaging and ENDS products policies on liquid nicotine, but it did not pass. This is creating a number of problems. Synar compliance checks can only cover tobacco products under state law so the definition of tobacco products needs to be broadened. Violation rates in states that do not classify ENDS products as tobacco products are increasing. If a violation breaks a municipal ordinance and it matches the state law, all the money goes to the municipality. Also, schools are currently forced to draft their own policies around ENDS products use within the schools. The Prevention Advisory Committee is brainstorming about the next step. Educating the community about ENDS products is important. A fact sheet can be found on ripac.org. The Prevention Strategic Plan was also discussed, and areas of focus in the next 3-5 years were identified, including: community partnerships; sustainability; alcohol, tobacco and other drug specific content; workforce development; and infrastructure. September 30th is the next Prevention Committee meeting from 10am -12pm in Room 226 at Barry Hall building. A recommendation is to check the regulations to see if there is a way of including the enforcement of underage tobacco use.

The Evidence-based Work Group Report is a subcommittee of the Prevention Advisory Committee. The workgroup’s purpose is to develop specific guidelines for ascertaining whether a given practice, policy, or program meets the existing standards for evidence-based practices in behavioral health. It also identifies the process by which innovative locally developed behavioral health practices could be designated as evidence-based practice. This work group is required under SAMSHA Partnership for Success Initiative, which is funding 12 communities to implement evidence-based practices. It is designed to bring together a panel, primarily of researchers, to develop criteria for establishing whether a practice meets the criteria for an evidence-based practice. The next step for the group is to finalize the three tiers of evidence based practice.

Block Grant update (Jim Dealy): The Block Grant Application is due September 1st and it is currently being written. A special meeting of the Governor’s council to review the draft Block Grant Application will be held on August 25th. Because of the fact that the state has already had to contract for the 2016 Block grant funds by the time the federal BG funds are awarded, planning for next year’s (FY 2017) Block Grant needs to be largely done by January, 2016. The Block Grant planning team will start this process as soon as this year’s Block Grant Application is submitted. BHDDH and DCYF are asking the Governor’s Council to participate in monthly planning meetings devoted to

planning for next year's Block Grant. The focus will be on identifying areas of need in our behavioral healthcare system and identifying plans and resources to meet those needs.

Members expressed interest in expanding the work of the evidence-based work group to include EBPs for treatment as well as prevention and using more of the data pulled from the SEOW in assessing the state's needs. BHDDH is also working with RIC and URI to obtain Master's level interns to help with needs assessments as well as grant applications. It is also working with Medicaid to see whether some of the things that are currently funded by the Block Grant may become Medicaid funded, which would free up Block Grant dollars for other uses.

RI Peers Recovery Specialists (Judith Fox): (Refer to PowerPoint handout) A peer recovery specialist is someone with lived experience who provides services that are recovery oriented, offers insight, and support. It includes both Mental Health and Substance Abuse. This service is a big shift in the paradigm of care, and the emphasis is on recovery by providing access to treatment and support services to meet people's individual needs. In 2014 BHDDH started receiving federal money from BRSS TACS, which is part of SAMSHA, to implement and to develop some of the infrastructure for the peer services. BRSS TACS is Federal money that supports states in designing and implementing strategic policies, practices and financing mechanisms and infrastructures to promote the implementation of recovery oriented supports, services and systems. The most important part of BRSS TACS is assembling a team that combines all the stakeholders throughout the state. The list of agencies that are represented as part of BRSS TACS is on the chart in the handout. There is also money allocated from the Block Grant for training and peer services. The RI Certification Board has information on peer certification on its website, and maintains a list of peer specialists certification and trainings.

Update from BHDDH (Becky Boss): The Medication Assisted Treatment TCE grant was not received. BHDDH is still waiting to hear on the Offender Reentry Grant. August 19th will be the first meeting of the Governor's Overdose Task Force, which is open to the public. There is a 50 state meeting convening in Washington on overdose in September and Becky Boss has been asked to present at that meeting. Rhode Island will be getting some national press attention about its efforts. BHDDH and Medicaid have been making plans with the Drug and Alcohol Treatment Association around substance abuse and residential treatment. There have been some very positive ideas. We will reconvene to see how that is going to work out in terms of short-term and long-term strategy with substance abuse and residential treatment, making sure that we are using evidence-based practices. It does not look like we are going to be able to maintain the 29

residential treatment beds that have closed in Woonsocket. Alternate locations are being pursued but the outcome is unclear. For the two grants that have been received, we are looking for high-level people as project directors who can do policy exchange work. There will be a National Drug Take Back Day on September 26th sponsored by DEA. Local communities are participating through the Substance Abuse Prevention Coalitions and also the local police departments. Check the DEA website or the RIPRC.org for listings of location. Providence is having a special Take Back Day event in collaboration with CVS – more information to come. Don't forget the Rally4Recovery on the 19th at Roger Williams National Park.

Update from EOHHS (Deb Florio): OHHS is currently focusing on the Reinventing Medicaid initiative. The RM Committee has issued a report of initiatives that shows how this state can save approximately \$50 million dollars in the Medicaid budget. What we are doing now in conjunction with our sister state agencies as part of EOHHS is fine-tuning every initiative, developing work plans and establishing specific things that need to be in each one. In some cases they are very specific already and in others cases, they are grand ideas in the sky that sound good but have to be worked out. A stakeholder group is being formed that will have its first meeting in a few weeks. We have a great deal of work to do to make these initiatives a reality, either in our state plans or in our Waivers. Our responsibility now is to identify all the things we want to do and then identify the barriers that make it difficult to implement things within the time frame that has been provided. Clearly the impetus is to get these things operative. There are approximately 45 initiatives – including those focusing on behavioral health, housing stabilization, state agency consistency, medication cost.

Update from DCYF (Chris Strnad): DCYF's primary initiative at this point to set up claiming for EBP home-based services. We are looking to save about \$750,000.00 in FY 2016. Harvard has agreed to work with us on a contracting process. We are working on a model for accessing the level of risk to children who are in their homes. We have extended all contracts, some for three months and others for six, while we evaluated all of them.

Old/New Business (Rich Leclerc): Jim asked that everyone please provide their email address if they are **not** currently receiving his emails and are regularly attending our meetings.

The VA is having a Mental Health Summit on September 10th.

The names of four individuals have been submitted to the Governor's Office for consideration as members of the Governor's Council. It is our goal to have a full slate of members before the SAMHSA application is sent in. We are checking with members who have not attended in over a year. If they are unable or unwilling to continue on the Council, we are requesting that they forward a letter of resignation so that their slot can be replaced.

On October 23rd RISAS will host a half-day conference on upstream approaches to improving behavioral health for children at the Crown Plaza in Warwick, Rhode Island. You have until August 31st to receive a discount for early registration.

Michelle managed to get a quick turn-around on the SAMSHA grant application and within about two weeks we received word that we would be receiving it. Great work, Michelle!

The meeting was adjourned by vote of the members.

Next Meeting: Tuesday, September 8, 2015, 1:00 P.M.

Barry Hall

Conference Room 126

14 Harrington Road, Cranston, RI 02920

Statutory and Public members, please let Jim Dealy know if you cannot attend

This meeting is open to the public.

If you plan to attend and you require special accommodations to ensure equal participation, please contact Jim Dealy at the Division of Behavioral Healthcare Services at 462-0118.

The Governor's Council on Behavioral Health was the key to the state's public notice strategy for the 2016 Combined Block Grant Application. The Governor's Council represents a broad spectrum of those involved with substance abuse and mental health prevention, treatment and recovery, including; consumers and people in recovery, families, government agencies, providers, advocates, veterans, youth, minority communities and advocates. One criterion for membership is that members be in a position to communicate widely within their respective communities, so that Council information, including details about the Block Grant, is disseminated beyond the Council. Besides the formal membership, the Council encourages participation by others in the behavioral health community, which has helped bring new populations into the Council. In addition, the Council maintains a large email list, so that all information on its work, including the Block Grant planning process, drafts of the Application, etc., go to a large number of people in the behavioral healthcare community. Thus, we believe, Block Grant information went to a great majority of those who might have had an interest in the planning process. In addition, the Block Grant Application was posted on BHDDH's website. The Primary Prevention narrative sections was posted in the RI Prevention Resource Center Provider Portal.

It should also be noted that, starting in the 2016 planning cycle, detailed information on past and projected Block expenditures, on the decision-making behind funding decisions and on the complexities of allocating Block Grant funds, are being shared with the Governor's Council. BHDDH and DCYF have committed to a fully transparent collaboration with the Council around future uses of the Block Grant. Collaborative planning with the Council has already begun for the 2017 Block Grant. These steps will empower the Council and, by extension, all those in its information network, to participate more effectively in future Block Grant planning cycles.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Richard Leclerc	Providers	Gateway Healthcare, Inc.	249 Roosevelt Avenue Pawtucket, RI 02860	
Richard Antonelli	Others (Not State employees or providers)		139 Lansdown Rd. Warwick, RI 02888 PH: 401-000-0000	
Linda Bryan	Parents of children with SED		485 Weaver Hill Rd W. Greenwich, RI 02817	
Sandra Delsesto	Others (Not State employees or providers)	Rhode Island College	600 Mt. Pleasant Ave Providence, RI 02908 PH: 000-000-0000	
Mark Fields	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		8 George St., Apartment 101 Pawtucket, RI 02860 PH: 401-000-0000	
Chaz Gross	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI Rhode Island	82 Pitman St Providence, RI 02906 PH: 401-331-3060	
Joseph Le	Others (Not State employees or providers)			
Frederick Trapassi	Providers	Phoenix Houses of New England	1058 Kingstown Rd Wakefield, RI 02879 PH: 401-000-0000	
Ann Mulready	Others (Not State employees or providers)	Rhode Island Disability Law Center	349 Eddy Street Providence, RI 02903 PH: 401-000-0000	
jamia mcdonald	State Employees	Rhode Island Department for Children, Youth and Families		
kenneth wagner	State Employees	Rhode Island Department of Education		
A.T. Wall	State Employees	Rhode Island Department of Corrections		

nicole alexander-scott	State Employees	Rhode Island Department of Health		
melba depena-affigne	State Employees	rhode island department of human services	57 howard avenue cranston, RI 02920 PH: 401-462-5300	
maria montanarao	State Employees	Rhode Island of Behavioral Healthcare, Developmental Disabilities and Hospitals		
charles fogarty	State Employees	Rhode Island Department of Elderly Affairs	74 west road cranston, RI 02920	
Bruce Long	Others (Not State employees or providers)		One Winifred Court Middletown, RI 02842	
David Spencer	Providers	Drug and Alcohol Treatment Association of RI	206 West Exchange Street Providence, RI 02903 PH: 401-521-5759	
Megan Clingham	Others (Not State employees or providers)	Mental Health Advocate		
Sarah Dinklage	Providers	Rhode Island Student Assistance Program	300 Centerville Road Warwick, RI 02886	
Cheri Cruz	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Parent Support Network of Rhode Island	1395 Atwood Avenue Johnston, RI 02919 PH: 401-467-6855	
Michael Tondra	State Employees	Office of Housing and Community Development	One Capitol Hill Providence, RI 02906 PH: 401-222-7901	Michael.Tondra@DOA.ri.gov
esther picon	Parents of children with SED	parent support network of rhode island	535 centreville road warwick, RI 02886 PH: 401-467-6855	
maxine heywood	Family Members of Individuals in Recovery (to include family members of adults with SMI)	parent support network of rhode island	535 centreville road warwick, RI 02886 PH: 401-467-6855	
brian sullivan	Providers	operation stand down	1010 hartford avenue, #1 johnston, RI 02919 PH: 401-383-4750	
jim mculty	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	mental health consumer advocates of rhode island	1280 north main street providence, RI 02904 PH: 401-831-6937	

george o'toole Individuals in Recovery (to include adults
with SMI who are receiving, or have
received, mental health services) anchor recovery center

pawtucket, RI
02680
PH: 401-739-
1262

Footnotes:

Block Grant Public Notice Corrective Action Plan

The Rhode Island department of Behavioral Healthcare, Developmental Disabilities and Hospitals is submitting the following corrective action plan to meet the requirements regarding public notice of the SABG contained in 92 USC 3000x-51:

- BHDDH will publish the Block Grant Application document (and any updated versions) on its public website as soon as it is made available, with language soliciting public comment and contact information for the Department's Block Grant Planning Team's lead person
- BDHHD will publish a draft of its application as soon as it is completed, but no later than one month prior to the BG application date. The draft will be posted on BHDDH's public website along with a request for comments and the contact information for the Block Grant Planning Team's lead person.
- BHDDH will post subsequent drafts of its application as they are finished.
- BHDDH will post the state's Block Grant Application immediately after it is submitted and will update this document with any required revisions.
- In addition, BHDDH will continue to involve the Governor's Council in the Block Grant planning process, including involving Governor's Council members in regularly scheduled joint Block Grant planning meetings and forwarding all Block Grant-related documents, including the Block Grant Application documents, drafts of the state's Block Grant application and the final application to the Council.

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	29	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	4	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED*	2	
Vacancies (Individuals and Family Members)	<input type="text" value="1"/>	
Others (Not State employees or providers)	6	
Total Individuals in Recovery, Family Members & Others	15	51.72%
State Employees	8	
Providers	5	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="1"/>	
Total State Employees & Providers	14	48.28%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="4"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	4	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="5"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

JUL 6 2015

Ms. Maria Montanaro
State of Rhode Island Department
of Behavioral Health Care Services
14 Harrington Road, Barry Hall #52
Cranston, RI 02920

Dear Ms. Montanaro:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the “Application Complete” function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA’s block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, “Management’s Responsibility for Internal Controls,” and one of the controls involves a review of how SAMHSA ensures states’ and jurisdictions’ compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

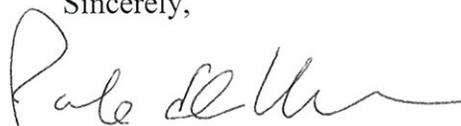
Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state’s chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state’s chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS’s Division of State and Community Systems Development. Enclosed is a State project officer directory.

Sincerely,

A handwritten signature in black ink, appearing to read "Paolo del Vecchio". The signature is fluid and cursive, with a long horizontal stroke at the end.

Paolo del Vecchio, M.S.W.

Director

Center for Mental Health Services

Substance Abuse and Mental Health Services Administration

cc: James Dealy
Ruth Anne Dougherty
Richard Leclerc

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory