



***Rhode Island Behavioral Health Project:
Supply Report***

Submitted to:

Rhode Island

Executive Office of Health and Human Services

Department of Health

Department of Behavioral Health, Developmental Disabilities, and Hospitals

Office of the Health Insurance Commissioner

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EXECUTIVE SUMMARY

Motivation. Rhode Island’s vision is to ensure that all of its residents have the opportunity to achieve the best possible mental health and well-being within healthy local communities that promote empowerment, inclusion, and shared responsibility. To meet this vision, Rhode Island must have a complete view of its behavioral health system. This must include information on Rhode Islanders’ service needs, how services are financed, where services are used, the quantity and costs of services, and the societal cost of untreated or undertreated behavioral illness. This report describes the supply of behavioral health providers and behavioral health service capacity. It is one of four main reports of the Behavioral Health Project: (1) Demand Report, (2) Cost Report, (3) Supply Report, and (4) Summary Report.

Methods. In collaboration with Rhode Island, Truven Health Analytics used a lifespan approach to understand the supply of behavioral health providers and services. The lifespan approach acknowledges the evidentiary links of mental and substance use disorders across an individual’s life, beginning with risk factors that emerge prenatally or in infancy and childhood, continuing with the emergence of mental and substance use disorders in adolescents and young adults, and, for some, leading to disability, intensive health care and social welfare service use, and high morbidity and mortality. An adequate supply of age-appropriate preventive interventions and treatment can help curb the impact of behavioral health disorders, provided that the best treatment practices are available within local communities.

To determine the availability of behavioral health services in Rhode Island, we analyzed a number of nationally and state-representative survey data sets as well as other sources of robust information. We focused on data from the most recent 3 years available. Primary data sources include: Area Health Resources Files (AHRF), National Mental Health Services Survey (N-MHSS), the National Survey of Substance Abuse Treatment Services (N-SSATS) and data specific to Rhode Island.

Key Findings for Children and Adolescents.

- Children and adolescents in Rhode Island face greater social and familial risks for the development of mental and substance use disorders than children in other New England states and the nation.
- Children and adolescents in Rhode Island experience relatively high rates of poverty. They are more likely to live with an unemployed parent, in a single-parent household, and in a less positive home environment.¹

¹ Woodward R, Mark TL, Levit, K. Rhode Island Behavioral Healthcare Project: Demand Report. Submitted to Rhode Island April 20, 2015.

- As noted by the 2014 Rhode Island Kids Count Fact Book, children most at risk of not achieving their full potential are children in poverty. Approximately one in five children in Rhode Island is poor.²

These risk factors lead to higher rates of mental health and substance use conditions.

- As they grow, children and adolescents in Rhode Island are more likely to develop attention deficit hyperactivity disorder and to use illicit drugs, compared with the national average of children and adolescents across other states.

Our analyses of the supply of behavioral health services in Rhode Island suggests that although Rhode Island has an innovative vision and system for addressing the needs of children and adolescents, the state may see significant benefits from greater investment in primary and second preventive services for these individuals and their family supports.

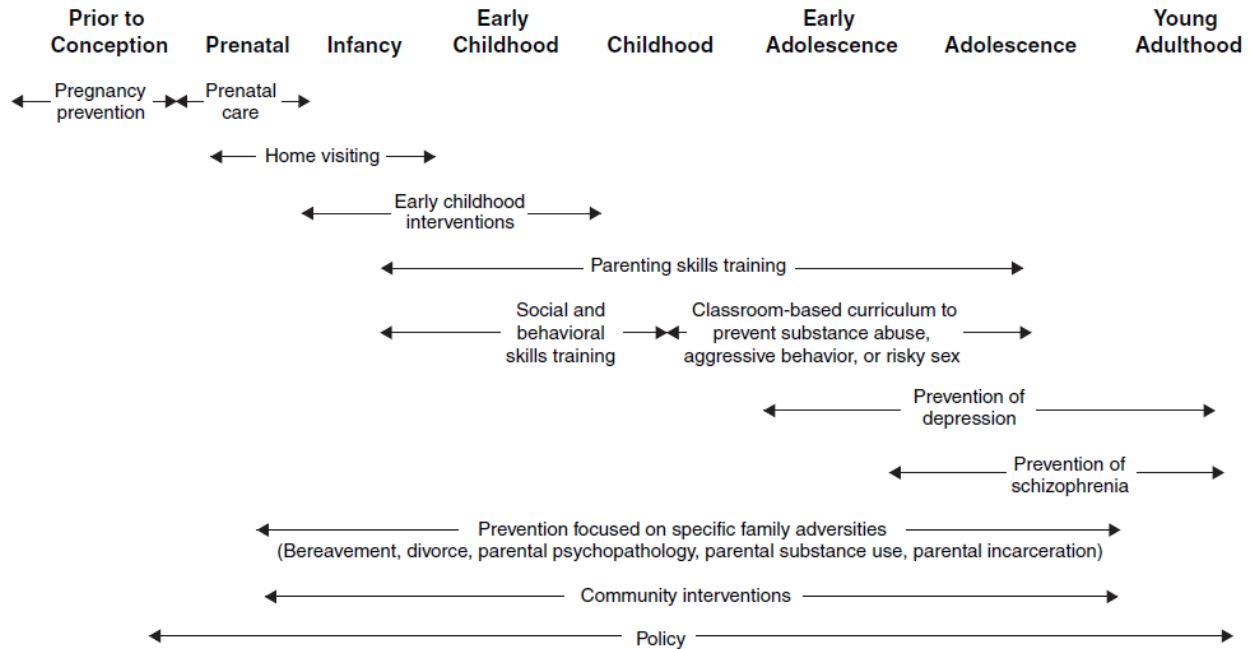
Figure 1 describes interventions that can be effective at preventing the development of mental and substance use disorders as children develop into young adults. As recently noted by the National Research Council and Institute of Medicine:

Supporting the development of children requires that infrastructure be in place in more than one system—public health, health care, education, community agencies—to support and finance culturally appropriate preventive interventions at multiple levels.³

² Rhode Island KIDS COUNT. 2014 Rhode Island Kids Count Factbook. Providence, RI: Author; 2014.
<http://www.rikidscount.org/Portals/0/Uploads/Documents/2014Factbook-noart.pdf>

³National Research Council and Institute of Medicine. 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. O’Connell ME, Boat T, Warner, KE, Eds. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press; 2009.

Figure 1. Interventions by Developmental Phase



Source: The National Academies. Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Report Brief for Policymakers. March, 2009.

Examples of effective preventive interventions include the following: pregnancy prevention (e.g., screening for substance use); home visiting programs (e.g., Nurse Family Partnership and Healthy Families New York); early intervention services; parenting skills training (e.g., Incredible Years, Positive Parenting Program, Strengthening Families Program; For Parents and Youth; Adolescent Transitions Program); comprehensive early education programs (e.g., Perry Preschool Program, Carolina Abecedarian Program, Child-Parent Center); family disruption interventions (e.g., New Beginnings Program); and school-based programs (e.g., Good Behavior Game, Life Skills Training, Linking Interests of Families and Teachers, Fast Track, Seattle Social Development Project, Adolescents Transitions Program).⁴

These programs have been shown to be effective in reducing the odds that a child will develop a mental or substance use disorder. They also have been found to reduce child maltreatment;

⁴ National Research Council and Institute of Medicine. 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. O’Connell ME, Boat T, Warner, KE, Eds. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press; 2009.

to reduce aggressive, disruptive, or antisocial behaviors among children; to improve parent-child interaction; to improve academic achievement, high school graduation rates, and college attendance; to increase employment and earnings; and to reduce arrest rates.⁵

The types of programs that Rhode Island provides today that they may want to expand or enhance include the following:

- Evidence-based home visiting (e.g., Healthy Families America, Nurse-Family Partnership, and Parents as Teachers; First Connections; Positive Parenting Program; Common Sense Parenting)
- Early intervention services
- Early childhood programs (e.g., Early Head Start)

Additionally, Rhode Island appears to have a shortage of Department of Children, Youth & Families case workers and step-down community services for children and adolescents following a psychiatric hospitalization. These services are provided across an array of settings, state agencies, and payers. Thus, coordination, performance monitoring, and accountability will be critical challenges in treatment-effective and cost-effective service implementation.

A key challenge for Rhode Island will be in moving the system from the delivery of reactive treatment services, to one focused on improving the health of its children through prevention and early intervention. As noted by the National Academy of Sciences:

Mental, emotional, and behavioral disorders incur high psychosocial and economic costs for the young people who experience them, for their families, and for the society in which they live, study, and will work. Yet there is a significant imbalance in the nation's efforts to address such disorders. People await their emergence and then attempt to treat them, to cure them if possible, or to limit the damage they cause if not. This happens with any number of expensive interventions, ranging from psychiatric care to incarceration. Myopically, we devote minimal attention to preventing future disorders or the environmental exposures that increase risk.

⁵ National Research Council and Institute of Medicine. 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. O'Connell ME, Boat T, Warner, KE, Eds. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press; 2009.

Key Findings for Adults.

- Adults in Rhode Island had the highest rate of general hospital admissions for mental health issues among adults in New England states and nationally.
- Rates of drug and alcohol use in Rhode Island typically are higher than the national average.⁶
- Rhode Island adults die more frequently from narcotics and hallucinogens than adults in other New England states.
- Adults in Rhode Island are more likely to report unmet need for treatment of mental and substance use disorders than residents in the other comparison states.

Behavioral health treatment services fall into three general categories: inpatient, outpatient, and medications or biomedical interventions. Inpatient care primarily includes short-term hospitalizations for psychiatric or life-threatening crises related to substance use disorders. Outpatient care primarily consists of outpatient visits in which therapies and medications may be provided. Outpatient providers may be professionals such as primary care physicians, psychiatrists, pediatricians, psychologists, social workers, counselors, and nurses that work in independent practices or facility organizations, such as community mental health clinics. An array of medications and some biomedical interventions such as electroconvulsive stimulation exist to treat mental and substance use disorders.

Although this array of outpatient, inpatient, medication, and biomedical interventions form the scaffolding for behavioral health treatment, this scaffolding is insufficient to provide high-quality, cost-effective behavioral health treatment; this is particularly the case for individuals with severe mental illnesses.⁷ Without the glue that ties these services together, these individuals often cycle into and out of hospitals, neglect to take their medications, develop physical illnesses such as diabetes and hepatitis, become homeless or are imprisoned, and are at much higher risk of early death.

The results of our analysis of Rhode Island's behavioral health system indicate that the scaffolding in Rhode Island already exists. Rhode Island does not appear to be lacking in hospital beds, most types of professionals who offer behavioral health treatment, or specialty

⁶ Woodward, R, Mark TL, Levit, K. Rhode Island Behavioral Healthcare Project: Demand Report. Submitted to Rhode Island April 20, 2015.

⁷ Kaplan L. The Role of Recovery Support Services in Recovery-Oriented Systems of Care. DHHS Publication No. (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Services, Substance Abuse and Mental Health Services Administration; 2008. <http://store.samhsa.gov/product/The-Role-of-Recovery-Support-Services-in-Recovery-Oriented-Systems-of-Care/SMA08-4315>

mental health or substance abuse facilities. However, the glue that allows this framework to produce high-quality, cost-effective results could be strengthened.

- Building up Rhode Island’s community-based behavioral health system is one way to strengthen and improve the state’s behavioral health treatment framework and reduce avoidable hospital admissions. Specific examples include:
 - After 2011, Rhode Island had no assertive community treatment programs. Additionally, Rhode Island lacks family psychoeducation. The state should consider working these evidence-based practices into its community treatment framework.
 - The rate of homelessness among those served by the Rhode Island mental health system was higher than the national average (5% versus 3.3%). Yet, only 2.6 percent of individuals with serious mental illness served by the Rhode Island mental health system received supportive housing.

- Another key consideration is improving transitions across systems of care, particularly from costly inpatient and institutionalized settings (e.g., jails), to community settings. For example:
 - Among Rhode Island Medicaid beneficiaries who were hospitalized for a mental illness, one in five had no follow-up mental health treatment in 30 days.

- Rhode Island may also want to examine the distribution of resources across the state. Although in general, Rhode Island appears to have an adequate supply of behavioral health specialists, for example, they may not be accessible by those most in need or exist in the correct specializations for particular needs. For example:
 - Of the five counties in Rhode Island, three are designated as having at least one community health center with a shortage of mental health professionals: Newport County (1), Providence County (6), and Washington County (1).
 - Rhode Island had a lower per capita number of substance abuse counselors and other behavioral health counselors than the national average. Rhode Island ranked lowest of all New England states for other behavioral health counselors and second lowest for substance abuse counselors, though other types of professionals (e.g., clinical social workers) provide counseling services in the state.

- Rhode Island had no mental health programs offering specialized services for traumatic brain injury. It had the lowest percent of mental health facilities offering programs specifically designed for Veterans or for individuals with Alzheimer’s disease or Dementia in 2010.
- Recent behavioral health treatment program closings in Rhode Island should be assessed and factored into the framework, including post-2012 closings for a significant number of community residential treatment beds.

INTRODUCTION

Rhode Island’s vision is to ensure that all of its residents have the opportunity to achieve the best possible mental health and well-being within healthy local communities that promote empowerment, inclusion, and shared responsibility. To achieve this vision, Rhode Island seeks a complete picture of its residents’ experience with the behavioral health care system. Delivering services and treatment in effective and efficient ways can improve outcomes and reduce costs. The Rhode Island Behavioral Health Project began in September 2014 to help achieve this goal. The Behavioral Health Project has four main deliverables: (1) Demand Report, (2) Cost Report, (3) Supply Report, and (4) Final Report. This Supply Report is the third in this series.

Context

Children in Rhode Island face greater risk factors for the development of mental and substance use disorders than other New England states.

- They are typically more likely to live in poverty, have an unemployed parent, have a single-parent household, and have a less positive home environment.
- The consequences of these higher risks emerge as the children age. Children and adolescents aged 5–17 years have higher rates of attention deficit hyperactivity disorder, and adolescents had higher rates of illicit drug use and marijuana use than the national average.

Among adults aged 18–44 years in Rhode Island, rates of drug and alcohol use are higher than the national average.

- Rhode Islanders have much higher age-adjusted death rates from narcotics and hallucinogens than the national average.
- Adults in Rhode Island were more likely to report unmet need for treatment of mental and substance use disorders than residents in the other comparison states.

These facts emphasize the importance of evaluating the number and types of behavioral health services and providers in Rhode Island that can be harnessed to meet this significant need.

Methods

In collaboration with Rhode Island, Truven Health Analytics used the lifespan approach to examine the need and supply of behavioral health services. The lifespan approach acknowledges the evidentiary links of mental and substance use disorders across an individual's life, beginning with risk factors that emerge in infancy and childhood, continuing with those that have the greatest impact on young adults, and ending with those that are most common in late adulthood. An adequate supply of age-appropriate interventions and treatment can help curb the impact of behavioral health disorders, provided that the best treatment practices are available within local communities.

In this Supply Report, we examined available data to determine behavioral health workforce and treatment capacity in Rhode Island as compared with other New England states and national averages. When possible, we analyzed how the supply information has changed over time in Rhode Island, across the other New England states, and for national averages.

We examined the following type of behavioral health providers and services:

- Preventive interventions for children and adolescents
- Hospitals
- Home and community support services
- Independent practitioners
- Substance use disorder specialty facilities
- Mental health specialty facilities
- Housing vouchers

To conduct these analyses, Truven Health primarily used the following data sources:

- Area Health Resources Files (AHRF)
- National Mental Health Services Survey (N-MHSS)
- National Survey of Substance Abuse Treatment Services (N-SSATS)

- Professional Association Data
- American Hospital Association Data
- Rhode Island Specific Data

These data sources are described in Appendix A.

The results help establish an understanding of provider supply, the adequacy of the workforce and treatment capacity, and opportunities for improvement in service provision.

Supply of Behavioral Health Providers and Services for Children and Adolescents (Ages 0–17 Years)

Mental health in childhood means reaching developmental and emotional milestones as well as learning healthy social skills and how to cope when experiencing related problems.⁸ Mentally healthy children have a positive quality of life and can function well at home, in school, and in their communities. Symptoms of mental disorders change over time as a child grows and may include difficulties with how a child plays, learns, speaks and acts or how the child handles his or her emotions. Symptoms often start in early childhood, although some disorders may develop throughout the teenage years. The diagnosis is often made in the school years and sometimes earlier.

Several decades of research have shown that early interventions during childhood can be effective in delaying or preventing the onset of mental and substance use disorders, thereby leading to potential lifetime benefits. Among children and adolescents with diagnosed mental and substance use disorders, a number of different types of treatment have been shown to be effective.

For the age group 0–17 years, Truven Health examined the supply measures described in Table 1.

⁸ Centers for Disease Control and Prevention. Children’s Mental Health. CDC website; last updated April 30, 2015. <http://www.cdc.gov/ncbddd/childdevelopment/mentalhealth.html>

Table 1. Key Measures and Their Data Sources for Children and Adolescents Aged 0–17 Years

Topic	Data Source	Measure
Independent Practitioners	AHRF	General Pediatricians (MDs) per 100,000 Adolescents
	AHRF	Child Psychiatrists (MDs) per 100,000 Adolescents
Hospital Capacity	BHDDH	Licensed Inpatient Psychiatric Beds for Children Bradley Children's Hospital Patient Discharges and Outpatient Visits
SUD Treatment Capacity	Website	SUD Treatment Facilities; Number and Clients Ages 0–17 (N and per 100,000 adolescents)
	N-SSATS	SUD Treatment Facilities with Programs for Adolescents
MH Treatment Capacity	N-SSATS	Residential Treatment Centers for Children (N and per 100,000 Adolescents)
	N-MHSS	MH Facilities Offering Treatment Programs Designed Exclusively for Adolescents With SED
	N-MHSS	MH Facilities Accepting Adolescents-Only Treatment
	Medicare Cost Reports ^a	Residential Treatment Centers for Children With SED MH Services Available to Children under Medicaid, Number Offered of Available
Other	MHUS ^b	Rhode Island DCYF Instate Licensed Beds and Out-of-State Placements
	DCYF Information collected by Kids Count; the Casey Foundation, and others	Use of routine alcohol and drug screening among pregnant women; Home Visiting Programs; Early Intervention Services; Early Childhood Programs; and Foster Care

Abbreviations: AHRF, Area Health Resources Files; BHDDH, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals; DCYF, Rhode Island Department of Children, Youth & Families; MD, medical doctor; MH, mental health; N-MHSS, National Mental Health Services Survey; N-SSATS, National Survey of Substance Abuse Treatment Services; RI, Rhode Island; SED, serious emotional disturbance; SUD, substance use disorder

^a As seen in Mental Health United States, 2010 (MHUS)

^b Data are based on the Substance Abuse and Mental Health Services Administration (SAMHSA) 2008 National Survey of Mental Health Treatment Facilities as seen in MHUS.

Note: See Appendix A for more information about data sources.

Pregnancy and Prenatal Prevention

Alcohol consumption, illicit drug use, and tobacco use during pregnancy have negative implications for maternal and child health. Appropriate early universal Screening, Brief Intervention and Referral to Treatment (SBIRT) for pregnant women is necessary to identify

women at risk and reduce the likelihood of continued drinking , illicit drug use, and smoking.⁹ In 2011, national data show that an estimated 9.4 percent of pregnant women drank in the past month. An estimated one of five women receiving Medicaid filled a prescription for an opioid during pregnancy.¹⁰ Among pregnant women in Rhode Island, 10 percent smoked during the last 3 months of pregnancy.

Despite the importance of screening, we did not find any data on the extent to which pregnant women in Rhode Island are being screened routinely for alcohol and illicit drug use. However, Table 2 displays recent years’ data on maternal and child health indicators in Rhode Island.

Table 2. Maternal and Child Health Indicators in Rhode Island

	HISPANIC/ LATINO	BLACK/AFRICAN AMERICAN ¹	NATIVE AMERICAN ¹	ASIAN & PACIFIC ISLANDER ¹	WHITE ¹	STATE
Percentage of pregnant women with delayed prenatal care ^{2±}	16.2	18.7	16.7*	16.3	10.5	12.8
Percentage of births to mothers with less than 12 years of education ²	29.5	17.3	31.7*	9.9	8.6	13.8
Percentage of infants with low birth weight ^{2¥}	7.7	11.4	10.6*	9.4	6.8	7.6
Rate of births to teens ages 15-19 (per 1,000 teens) ²	50.8	34.4	123.1*	14.4	13.4	21.4
Infant mortality rate (per 1,000 live births) ^{2£}	5.8	11.2	+	6.3	5.3	6.6
Rate of children with incarcerated parents (per 1,000 children) ²	17.7	63.8	22.1*	4.0	8.0	13.1

Sources: ² Rhode Island Department of Health, Center for Health Data and Analysis, 2009-2013
³2014 Rhode Island KIDS COUNT Factbook
[±]Delayed prenatal care is defined as care received after the first trimester or no prenatal care received
[¥]Low birth weight is defined as less than 2,500 grams or 5.5 pounds
[£]Infant mortality rate is defined as the number of infants who died before their first birthday per 1,000 live births
⁺Sample too small for meaningful analysis
^{*}Use caution in interpreting result; estimate is considered statistically unreliable due to small sample size
¹ Hispanic ethnicity may be included in racial category

Home Visiting

Home visiting is an intensive intervention that targets infant development. Although their procedures are highly variable, home visiting programs generally involve a nurse or paraprofessional beginning visits to the mother during the pregnancy or just after birth, and

⁹ O'Brien PL. Performance measurement: a proposal to increase use of SBIRT and decrease alcohol consumption during pregnancy. *Matern Child Health J.* 2014;18(1):1-9.

¹⁰ Desai RJ, Hernandez-Diaz S, Bateman BT, Huybrechts KF. Increase in prescription opioid use during pregnancy among Medicaid-enrolled women. *Obstet Gynecol.* 2014;123(5):997-1002.

continuing to do so through the first few years of the child’s life.¹¹ The majority of programs provide parenting education, information about child development, social support to parents, encouragement of positive parent–child interactions, and social and health services. Some also provide case management services and health and developmental screening for children.¹² Benefits of home visitation programs include reduced child abuse, improved achievement test scores, and decreased likelihood of arrest later in life.¹³

Rhode Island uses Maternal, Infant, and Early Childhood Home Visiting (MIECHV) federal funding to support implementation of three evidence-based home visiting models: Healthy Families America, Nurse-Family Partnership, and Parents as Teachers.¹⁴ As of 2013, there were 288 families enrolled in one of the three MIECHV–funded, evidence-based home visiting programs in Rhode Island. A total of 92 percent of the families lived in one of the four core cities, and 8 percent lived in the remainder of the state.

Home-based Early Head Start is also recognized as an evidence-based home visiting program that improves child outcomes. As of October 2013 in Rhode Island, there were 363 children enrolled in home-based Early Head Start.

Rhode Island also operates First Connections—a statewide, short-term home visiting program designed to help families get connected to needed resources. In 2013 in Rhode Island, a total of 3,598 children received at least one First Connections home visit. Fifty-six percent of the children lived in one of the four core cities, and 44 percent lived in the remainder of the state.¹⁵

Early Intervention Services

Early Intervention is a program that promotes the growth and development of infants and toddlers.¹⁵ States are required by the federal *Individuals with Disabilities Education Act (IDEA)*

¹¹ National Research Council and Institute of Medicine. 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. O’Connell ME, Boat T, Warner, KE, Eds. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press; 2009.

¹² Sweet MA, Appelbaum ML. Is home visiting an effective strategy? A metaanalytic review of home visiting programs for families with young children. *Child Development*. 2004;75:1435-1456.

¹³ National Research Council and Institute of Medicine, 2009.

¹⁴ Rhode Island KIDS COUNT. 2014 Rhode Island Kids Count Factbook. Providence, RI: Author; 2014. <http://www.rikidscount.org/Portals/0/Uploads/Documents/2014Factbook-noart.pdf>

¹⁵ Family Voices. Connecting the Dots. A Guide to Finding Services for People with Disabilities in Rhode Island. 2011. http://www.fv-ncfpp.org/files/6413/1711/4820/family_voices_resource_guide_2011_FINAL_reduced.pdf

*Part C*¹⁶ to identify and provide appropriate Early Intervention services to all infants and toddlers younger than 3 years who have developmental delays or have a diagnosed physical or mental condition that is associated with a developmental delay. Children referred to Early Intervention receive a comprehensive developmental evaluation to determine if they are eligible for the program. A goal of Early Intervention is to provide support to families to help their children develop to their fullest potential.

In Rhode Island in 2013, there were 11 certified Early Intervention provider agencies.¹⁷ In 2013, 4,168 children received Early Intervention services, a 5 percent increase from 2012.¹⁸ Of these, 81 percent were eligible under the developmental delay category, 13 percent under the single established condition category, and 6 percent under the multiple established conditions category.

Early Intervention programs are required to provide transition services for children who are enrolled in Early Intervention and who may be eligible for special education at age 3 years. In 2013, 36 percent of the 2,059 children who reached age three while in Early Intervention were determined to be eligible for preschool special education, 12 percent were found not eligible for special education, and 6 percent did not have eligibility determined when exiting Early Intervention. The remaining enrollees completed their service plan prior to reaching the maximum age for Early Intervention, moved out of state, withdrew, died, or were otherwise unreachable for follow-up.

Because maltreated infants and toddlers are six times more likely to have a developmental delay, federal legislation requires states to refer children to Early Intervention for an eligibility assessment if they are younger than 3 years and have been involved in a substantiated case of child abuse or neglect. In 2013 in Rhode Island, there were 838 infants and toddlers under age three who were maltreated. Of these, 50 percent were referred to Early Intervention for an eligibility assessment, 26 percent were referred to *First Connections* for screening, 9 percent were already enrolled in Early Intervention, and 16 percent were not referred because the case was closed or the family refused to give consent.

¹⁶ U.S. Department of Education. IDEA 2004: Building the Legacy. Part C (Birth–2 Years Old). ED.gov website. <http://idea.ed.gov/part-c/search/new>

¹⁷ Rhode Island KIDS COUNT. 2014 Rhode Island Kids Count Factbook. Providence, RI: Author; 2014. <http://www.rikidscount.org/Portals/0/Uploads/Documents/2014Factbook-noart.pdf>

¹⁸ Ibid.

Early Childhood Programs

Early Head Start

Early Head Start is a federally funded program that provides comprehensive child developmental services to families with children under 3 years and to pregnant women. The goal of Early Head Start is to enhance children’s physical, social, emotional, and cognitive development; enable parents to be better caregivers and teachers to their children, and help parents meet their own goals.¹⁹

Early Head Start has been shown to produce significant cognitive, language, and social-emotional gains in participating children as well as more positive interactions with their parents.²⁰ Early Head Start parents provide their children with more emotional support and more opportunities for language and learning, and they are more likely to pursue education and job-training activities and to be employed. Children who enroll in preschool after Early Head Start have better outcomes in early reading skills.

In 2013 in Rhode Island, federal funding enabled 233 children and pregnant women to participate in Early Head Start from the four core cities (4 percent of the estimated income eligible population) and 282 children from the remainder of the state (9 percent of the estimated income-eligible population). The estimated percentage of the eligible population enrolled in Early Head Start for each core city is the following: Central Falls, 8 percent; Pawtucket, 4 percent; Providence, 5 percent; and Woonsocket, 0 percent.

Early Learning Programs and Child Care

Nationally, 42 percent of infants younger than 1 year and 73 percent of preschoolers between 3 and 5 years regularly participate in a non-parental early care and education arrangements. Participation in early care and education varies by family income, with 63 percent of children aged birth to 5 years living in households at or above the poverty line enrolled in child care or early learning programs versus 49 percent of those in households below the poverty line.

¹⁹ Family Voices. Connecting the Dots. A Guide to Finding Services for People with Disabilities in Rhode Island. 2011. http://www.fv-ncfpp.org/files/6413/1711/4820/family_voices_resource_guide_2011_FINAL_reduced.pdf

²⁰ National Research Council and Institute of Medicine. 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. O’Connell ME, Boat T, Warner, KE, Eds. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press; 2009.



Enrollment in center-based programs increases as children get older: 28 percent of infants younger than 1 year participate in a center-based program, and 78 percent of preschoolers (children aged 3 to 5 years) are enrolled in a center. Between 2010 and 2012, 73 percent of Rhode Island children younger than 6 years had all parents in the workforce, which is a higher rate than the national average of 65 percent.

Rhode Island offers child care assistance to families that meet income requirements. Families that participate in the Rhode Island Works Program automatically meet the income requirements for child care assistance.

Rhode Island's \$50 million Race to the Top Early Learning Challenge Grant, awarded in December 2011, is designed to increase the quality of early learning programs and strengthen the workforce statewide. It has a focus on programs and staff serving low-income and disadvantaged children.

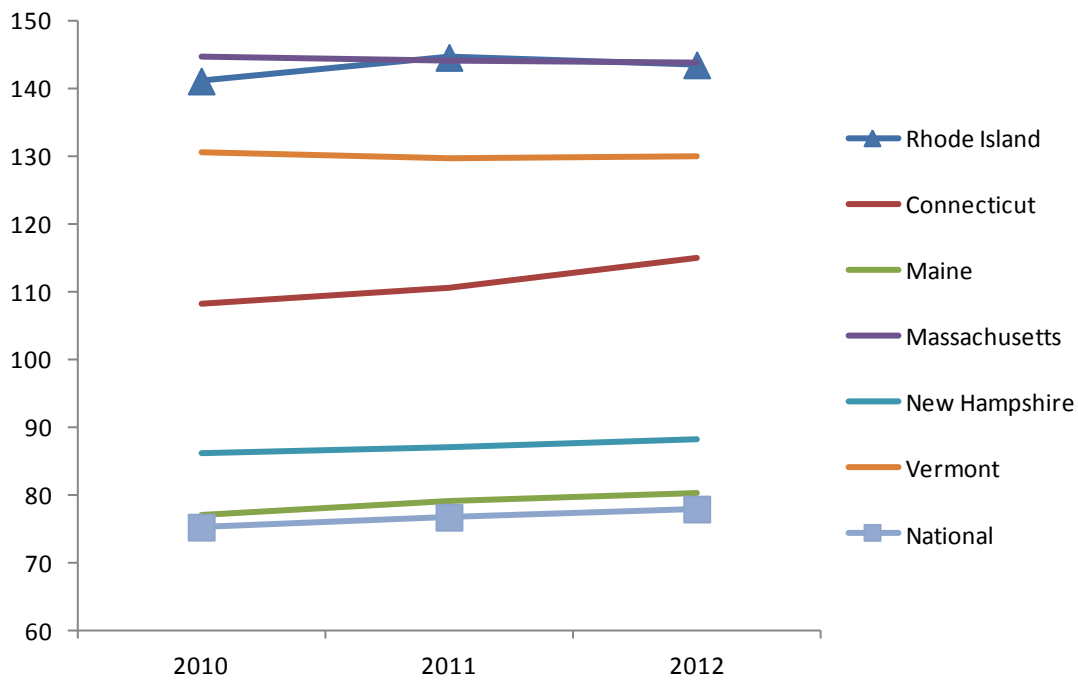
The number of licensed early learning center slots for infants and toddlers (children younger than 3 years) in Rhode Island has increased 15 percent over the past 12 years, growing from 5,121 in 2003 to 5,909 in 2014. The number of licensed slots for preschoolers (children aged 3 to 5 years) has grown 7 percent between 2003 and 2014—from 12,451 to 13,300. The number of licensed family child care slots has declined 55 percent from a peak high of 8,601 in 2006 to 3,847 in 2014.

Physicians and Practitioners

Pediatricians

Pediatricians provide a significant amount of behavioral health treatment to children. From 2010 through 2012, Rhode Island had an average of 143 pediatricians per 100,000 individuals aged 0–17 (Figure 2). This number was the second highest across New England states, and it was significantly higher than the national average of 76.6.

Figure 2. Number of Pediatricians per 100,000 Children and Adolescents, 2010–2012

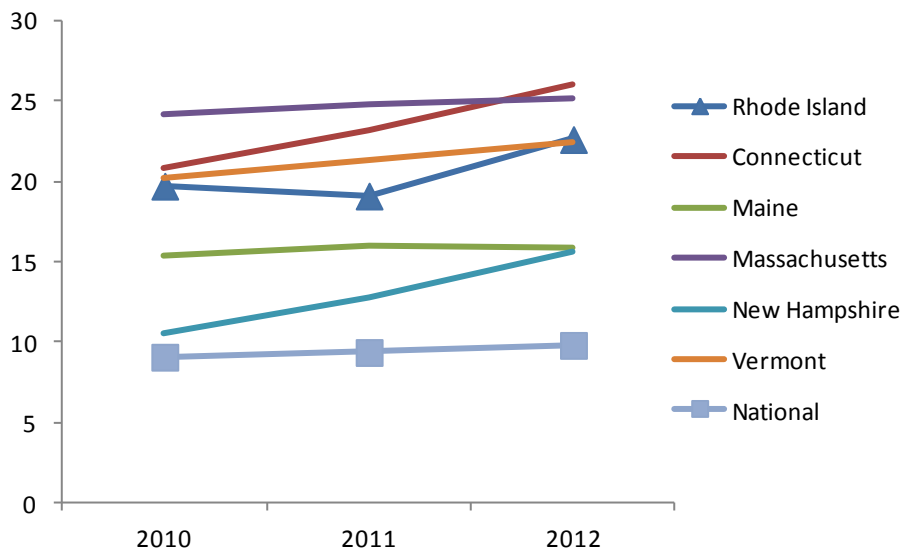


Source: Area Health Resources Files and Census population (aged 0–17 years) estimates for 2010, 2011, and 2012. See 0–17: Table 1 in Appendix B.

Child Psychiatrists

From 2010–2012, the number child psychiatrists, involved in patient care per 100,000 individuals aged 0–17 rose from 19.7 to 22.6 in Rhode Island (Figure 3). Rhode Island fell within the range across New England states and was higher than the national average during this time period for child psychiatrists per 100,000 children and adolescents.

Figure 3. Number of Child Psychiatrists per 100,000 Children and Adolescents, 2010–2012



Source: Area Health Resources Files and Census population (aged 0–17 years) estimates for 2010, 2011, and 2012. See 0–17: Table 2 in Appendix B.

Department of Children, Youth & Families Case Workers

Rhode Island is facing a shortage of Department of Children, Youth & Families (DCYF) case workers, as evidenced by their 24 percent vacancy rate in 2012. Moreover, the case loads of current case workers is about 21 cases per DCFY worker, which is much higher than the national best practices target of 14 cases per worker.^{21,22}

Substance Use Disorder Specialty Providers

On a 1-day census in 2012, Rhode Island had 323 clients aged 0–17 years who were receiving treatment for substance use disorders.²³ In 2010 and 2012 respectively, Rhode Island had 222 and 149 clients in this age group who were receiving treatment for substance use disorders per 100,000 children and adolescents.²⁴ These rates fell within the range of New England states and were higher than the national averages (see Figure 4 for 2012 data).

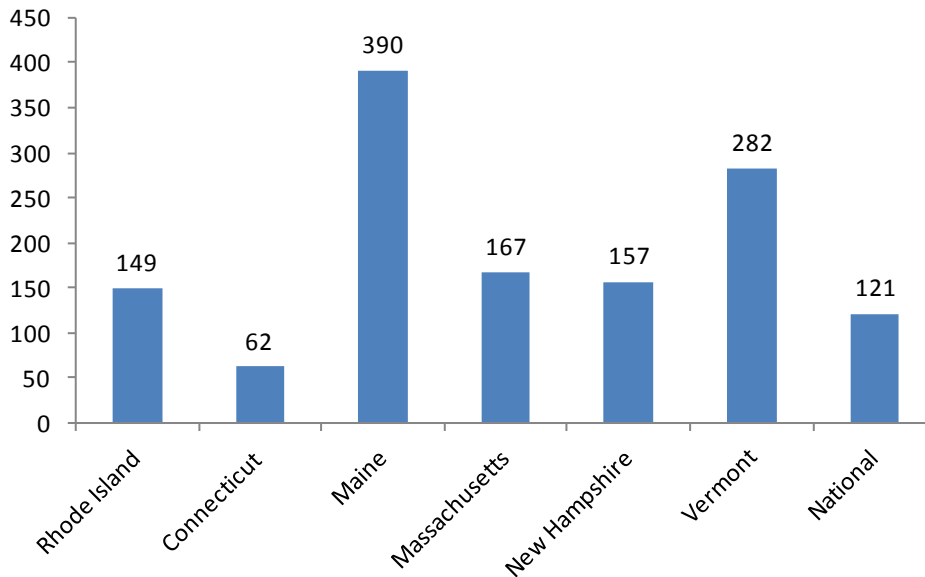
²¹ The Annie E. Casey Foundation. Rhode Island Department of Children, Youth & Families. Assessment, Findings, and Recommendations. May 20, 2014.

²² Rhode Island Senate. Senate Task Force on the Department of Children, Youth, and Families and the Family Care Networks. January, 2015. <http://www.rilin.state.ri.us/Reports/Family%20Care%20Networks.pdf>

²³ Source: National Survey on Substance Abuse Treatment Services (N-SSATS). One-day census taken on March 31, 2012.

²⁴ Source: N-SSATS, 2012.

Figure 4. One-Day Census of Clients Aged 0–17 Receiving Treatment for Substance Use Disorders per 100,000 Children and Adolescents, 2012



Source: National Survey on Substance Abuse Treatment Services (N-SSATS). One-day census was taken on March 31, 2012. See 0–17: Table 4 in Appendix B.

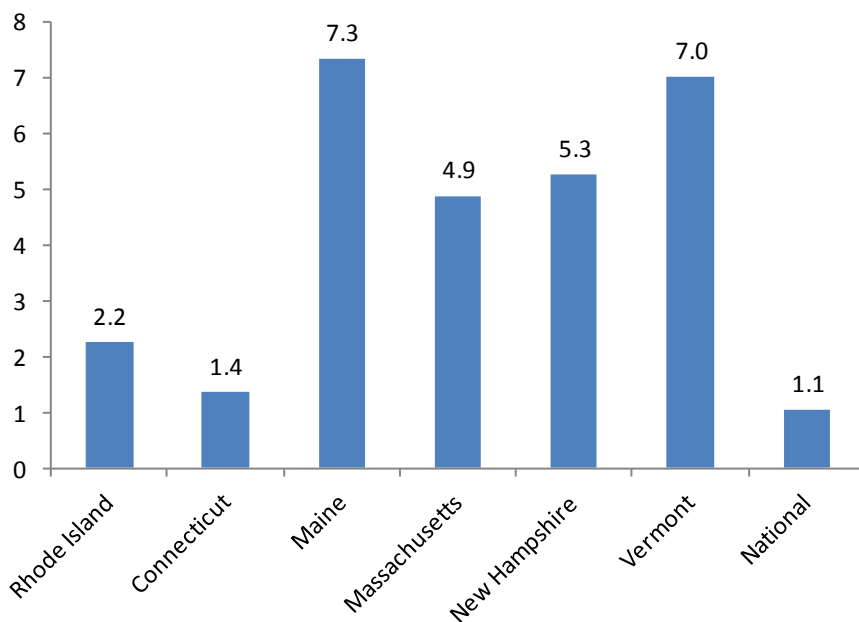
Rhode Island had the second-highest percentage of substance use disorder treatment facilities with programs for adolescents among New England states in years 2010, 2011, and 2012. However, this percentage declined from 28.3 to 20.6 during 2010 to 2012. In 2010, Rhode Island had 15 substance abuse treatment facilities with programs for adolescents, and in 2012 the number declined to 13 (see 0–17 Table 5 in Appendix B).

Residential Treatment Centers for Children

In 2010, Rhode Island had five residential treatment centers (RTCs) specifically for children.²⁵ Two of these facilities provided less than 24-hour outpatient or day treatment or partial hospitalization. In 2010, Rhode Island had 2.2 RTCs for children per 100,000 individuals in this age range. This rate was the second lowest among New England states but higher than the national average (Figure 5), and should be re-assessed when more recent data become available.

²⁵ Source: 2010 National Mental Health Services Survey (N-MHSS).

Figure 5. Number of Residential Treatment Centers for Children per 100,000 Adolescents, 2010



Source: 2010 National Mental Health Services Survey (N-MHSS). See 0–17: Table 6 in Appendix B.

Note: More recent survey data, when it becomes available, should be assessed as Rhode Island has had shifts in its behavioral health treatment design since 2010.

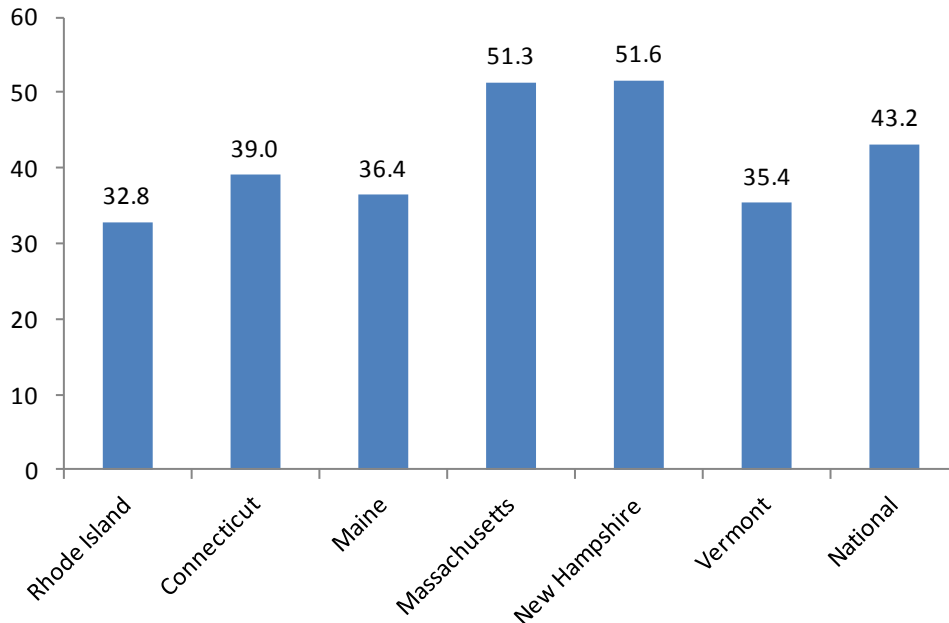
Mental Health Facilities and Services

Mental Health Facilities with Programs Designed for Children and Adolescents with Serious Emotional Disturbance

In 2010, Rhode Island had 22 mental health facilities offering treatment programs specifically for children and adolescents with serious emotional disturbance.²⁶ This represented 32.8 percent of total mental health facilities in the state, which was the lowest of the New England states and was lower than the national average (Figure 6). Given higher unmet need among children in Rhode Island relative to other New England states, this slightly lower rate of mental health facilities offering treatment specifically for children and adolescents with serious emotional disturbance may be a deficit that Rhode Island may need to address, once updated information is available and assessed.

²⁶ Source: 2010 National Mental Health Services Survey (N-MHSS).

Figure 6. Percentage of Mental Health Facilities Offering Treatment Programs or Groups Designed Exclusively for Children and Adolescents with Severe Emotional Disturbance, 2010

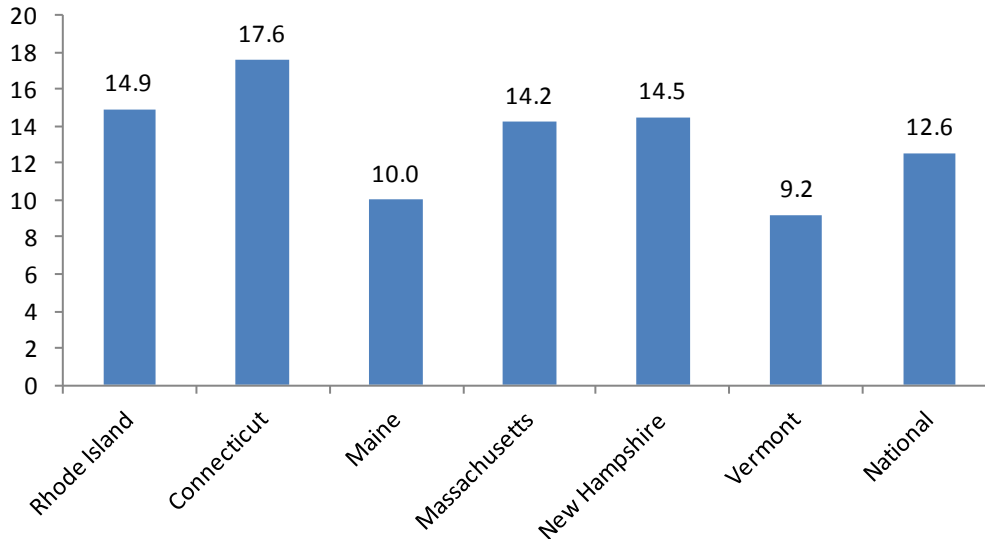


Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2010 National Mental Health Services Survey (N-MHSS). See 0–17: Table 7 in Appendix B.

Note: More recent survey data, when it becomes available, should be assessed as Rhode Island has had shifts in its behavioral health treatment design since 2010.

In 2010, Rhode Island had 10 facilities that only accepted children and adolescents for treatment, representing 15 percent of total mental health facilities in the state. This percentage fell within the middle range of New England states and was slightly higher than the national average (Figure 7). This percentage should be re-assessed when more recent data become available.

Figure 7. Percentage of Mental Health Facilities Accepting Adolescents-Only for Treatment, 2010



Source: 2010 National Mental Health Services Survey (N-MHSS). See 0-17: Table 8 in Appendix B.

Notes: This percentage should be re-assessed when more recent data become available, as Rhode Island has had shifts in its behavioral health treatment design since 2010.

Hospitals Providing Behavioral Health Treatment for Children

Bradley, Butler, and Hasbro hospitals offer behavioral health treatment for children and adolescents (Table 2). Bradley Hospital—a nonprofit hospital located in East Providence, Rhode Island—is the nation’s first pediatric psychiatric hospital; it has 60 licensed inpatient beds.²⁷ In 2013, Bradley hospital had 1,683 discharges and 19,806 outpatient visits.²⁸

In 2012, Bradley Hospital joined with Hasbro Children's Hospital to open an eight-bed, medical-psychiatric inpatient unit for patients aged 6–18 years. The unit serves patients with both acute mental health and medical health conditions.²⁹

Butler Hospital has an adolescent treatment unit that provides psychiatric treatment and support for teenagers aged 13–17 years. Treatment programs are offered for depression, anxiety, addictions, and other mental illnesses.³⁰

²⁷ Source: Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH).

²⁸ Source: Bradley Hospital, www.bradleyhospital.org. Accessed 2/24/15.

²⁹ Source: BHDDH.

³⁰ Source: Butler Hospital website. <http://www.butler.org/adolescentunit/index.cfm>. Accessed February 24, 2015.

Table 3 displays 24-hour psychiatric beds for children and adolescents in Rhode Island in 2015.

Table 3. Number of 24-Hour Psychiatric Beds for Children and Adolescents in Rhode Island, 2015.

Hospital	24-Hour Beds
Bradley Hospital	60
Butler Adolescent Treatment Unit	11
Hasbro Children's Hospital	8
TOTAL	79

Source: Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) via personal communication on June 2nd, 2015.

When a child or adolescent needs behavioral health treatment at an inpatient psychiatric hospital or in another placement in the community but there is no appropriate placement available, they may wait for a day or more in emergency departments and/or be admitted to (i.e., “boarded at”) medical floors at acute care hospitals. “Boarders” must wait for appropriate treatment and may require constant monitoring by staff so that they do not injure themselves or others.

In 2013, 282 children and adolescents younger than 18 years with a psychiatric diagnosis were “boarded” for an average of 2 days at Hasbro Children’s Hospital or Rhode Island Hospital. This is a slight decrease from 2012 (291) and a 27 percent reduction from 2011, when there were 388 boarders.

When a child or adolescent is ready to leave the psychiatric hospital and needs a *stepdown placement* of lesser clinical intensity but there is not one available or there is no other safe placement at a treatment program or at home, the individual is referred to as “stuck.” Bradley Hospital reported having an average of two stuck kids per day in FFY 2013, which was the same rate as in FFY 2012.

Child and Adolescent Intensive Treatment Services

The Child and Adolescent Intensive Treatment Services (CAITS) program, which is administered by the Rhode Island Executive Office of Health and Human Services as an in-plan benefit under RIte Care, aims to reduce inpatient psychiatric hospitalizations and residential treatment among Medicaid-eligible children and adolescents with moderate to severe emotional and/or

behavioral disorders. CAITS provides up to 16 weeks per year of intensive home- and community-based treatment via individual and/or family therapy, family training, and support worker services. In 2013, 1,695 children and adolescents received services from 10 CAITS provider agencies. About half (56 percent) of the adolescents served by CAITS were older than 12 years, whereas 38 percent were aged 6 to 11 years, and 6 percent were aged 5 years or younger.

Foster Care

Out-of-State Placements

DCYF out-of-state placements totaled 46, 42, and 71 for fiscal years 2012, 2013, and 2014, respectively. These placements had risen to 87 as of April 1, 2015.³¹

Use of Congregate Care

According to a recent analysis by the Annie E. Casey Foundation, Rhode Island has made significant progress in reducing the overall population of children in Rhode Island DCYF care and group placements. Nevertheless, the Rhode Island DCFY has a greater percentage of children in group settings than most states, and this percentage is almost twice the national average.³²

Summary

Analyses of data for individuals aged 0–17 years indicated the following primary results:

- Rhode Island had the second highest number of pediatricians per 100,000 children and adolescents of the New England states—a rate that was significantly higher than the national average.
- Rhode Island’s rate of psychiatrists responsible for patient care per 100,000 children and adolescents fell within the range of New England states and was higher than the national average. The state’s rate increased from 2010 to 2012.
- The number of children and adolescents with substance use disorders per 100,000 individuals in this age group in Rhode Island fell within the range of New England states, but this number was higher than the national average.

³¹ Source: Rhode Island Department of Children, Youth, & Families.

³² The Annie E. Casey Foundation. Child Welfare Strategy Group. Rhode Island Department of Children, Youth, and Families. Assessment, Findings and Recommendations. May 20, 2014.

- Rhode Island had the second-highest number of substance use disorder treatment facilities with programs for adolescents among New England states, but this number dropped from 15 facilities in 2010 to 13 facilities in 2012.
- Among the New England states, Rhode Island had the lowest percentage of mental health treatment facilities offering programs specifically for children and adolescents with SED in 2010; this rate also was lower than the national average.
- There were 87 adolescents in out-of-state residential treatment programs in July 2014 in Rhode Island, compared with 46 in July 2012.
- Although the rate has declined over time, Rhode Island’s DCFY still has a greater percentage of children in group settings than most states, and this percentage is almost twice that of the national average.
- Rhode Island had higher rates of congregate care than most other states as a result of foster family and therapeutic care recruitment.
- Rhode Island had more children in residential treatment than in homes.
- Hospitals offering psychiatric treatment for children in Rhode Island report that significant numbers of children are “stuck” in the hospital because of a lack of transitional community services.

SUPPLY OF BEHAVIORAL HEALTH PROVIDERS AND SERVICES FOR ALL AGES

Truven Health examined a number of supply measures as described in Table 4. We discuss many of the results of the analyses in the body of this report. We include more detailed information in table form in Appendix B.

Table 4. Key Measures and Their Data Sources for All Ages, by Topic

Topic	Data Source	Measure
Independent Practitioners	AHRF	Primary Care Physicians
	AHRF	Psychiatrists
	Association Data (in BHUS)	Psychologists
	Association Data (in BHUS)	Clinical Social Workers
	Association Data (in BHUS)	SUD Counselors and other Counselors
Hospital Capacity	AHA (in KFF)	Total Hospitals
	AHA (in KFF)	General Hospital Beds
	AHA (in KFF)	Short-Term General Hospitals with SUD Inpatient Care
	AHA (in KFF)	Short-Term General Hospitals with Psychiatric Care Licensed Psych Beds (IP, sub-acute, residential, and detox)
SUD Treatment Capacity	Rhode Island	
	N-SSATS	SUD Treatment Facilities and Clients
	N-SSATS	Opioid Treatment Providers and Clients
	N-SSATS	SUD Treatment Facilities by Program for Select Patient Groups
	N-SSATS	SUD Treatment Facility Capacity and Utilization Rate
MH Treatment Capacity	Rhode Island	Detoxification Services
	Rhode Island	BHDDH-Licensed Residential Beds for Co-Occurring SUD and MH Issues
	N-MHSS	MH Facilities
	N-MHSS	MH Treatment Facilities by Program for Select Patient Groups
	N-MHSS	SUD Recovery Centers, Recovery Beds, Peer-Run Centers, Clubhouses, Recovery Coaches, and Peer Behavioral Health Specialists, and other community support services
Other	Rhode Island	Evidence-Based Practices including Assertive Community Treatment teams
	Rhode Island	
	SAMHSA Health Resource Services Administration	Mental Health Professional Shortages
	SAMHSA buprenorphine physician and treatment locator	Buprenorphine waived physicians Coverage of medications to treat substance abuse treatment
	SAMHSA Rhode Island	Housing Assistance

Abbreviations: AHA, American Hospital Association (Annual Survey of Hospitals); AHRF, Area Health Resources Files; BHDDH, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals; BHUS, Behavioral Health, United States, 2012; KFF, Kaiser Family Foundation; MH, mental health; N-MHSS, National Mental Health Services Survey; N-SSATS, National Survey of Substance Abuse Treatment Services; RI, Rhode Island; SUD, substance use disorder

Note: See Appendix A for more information about data sources.

Hospitals

Inpatient treatment is a critical part of the care continuum for individuals with behavioral health conditions, particularly for individuals in crisis and/or at risk of harm to themselves or others. However, high inpatient utilization rates may be a sign of poor treatment and a lack of community outpatient treatment alternatives.

Rhode Island had the highest rate of hospital admissions per capita for mental health conditions and substance use conditions among New England states. The rate of mental health admissions was 68 percent higher than the national average, and the rate of substance abuse admissions was 76 percent higher than the national average.³³ Rhode Island also spent relatively more on behavioral health inpatient treatment than the other New England states.³⁴

Hospitals Providing Behavioral Health Treatment

In 2015, Rhode Island has eight licensed inpatient psychiatric care units in hospitals (Table 5). Of Rhode Island's 11 general hospitals, 6 have psychiatric care units (an increase from 3 in 2009). Rhode Island has one stand-alone psychiatric hospital (Eleanor Slater Hospital).

The American Society of Addiction Medicine (ASAM) has a national set of criteria for providing outcome-orientated and results-based care in the treatment of addiction. The criteria define five broad levels of care. Level IV is the highest of these and represents medically managed intensive inpatient services.³⁵ Roger Williams Medical Center has inpatient substance use disorder services at ASAM level IV, and it is the only hospital in Rhode Island providing this level of care.

Additionally, Rhode Island has 29 sub-acute beds as of 2015, at Community Care Alliance (13 beds) and The Providence Center's Acute Stabilization Unit (16 beds).

³³ Woodward, R, Mark TL, Levit, K. Rhode Island Behavioral Healthcare Project: Demand Report. Submitted to Rhode Island April 20, 2015.

³⁴ Yee T, Mark TL, Levit K. Rhode Island Behavioral Healthcare Project: Demand Report. Submitted to Rhode Island April 20, 2015.

³⁵ American Society of Addiction Medicine. The ASAM Criteria. ASAM website. <http://www.asam.org/publications/the-asam-criteria/about/>. Accessed May 3, 2015.

Table 5. Number of Inpatient Psychiatric Beds by Hospital for Adults in Rhode Island, 2015

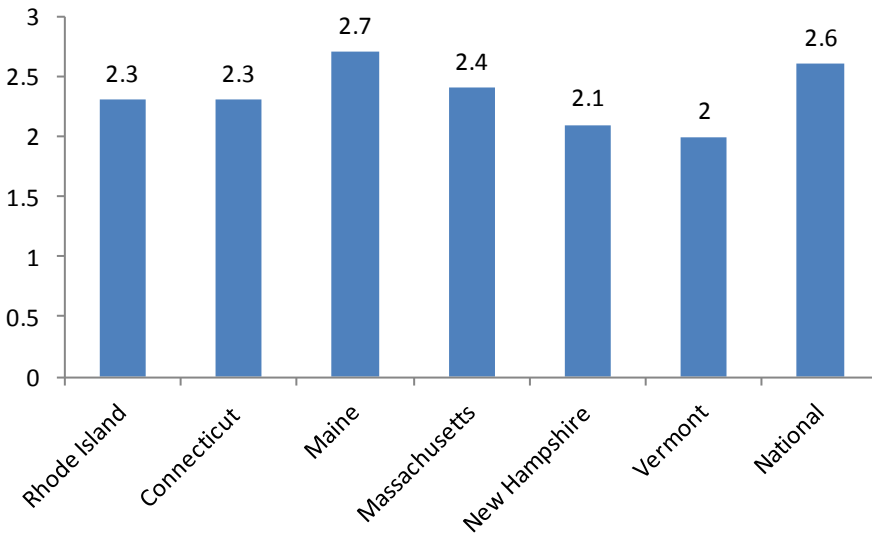
Hospital	Beds (N)
Eleanor Slater Hospital	
Long-term beds	150
Butler Hospital	132
Kent Hospital	
Inpatient voluntary beds	12
Psychiatric unit at Butler	29
Landmark Hospital	18
Newport Hospital	15
Veterans Hospital	21
Rhode Island Hospital	56
CharterCare	
Roger Williams Medical Center ^a	39
St. Joseph Hospital	63
TOTAL	535

Source: Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH), via personal communication, June 2nd, 2015.

^aIncludes 15-bed inpatient locked/voluntary medical detoxification unit. Roger Williams is the only hospital in Rhode Island with inpatient substance use disorder services at ASAM level 4.

The number of general hospital beds in Rhode Island per 1,000 population was 2.4, 2.3, and 2.3 for years 2010, 2011, and 2012, respectively. This rate was similar to other New England states and was slightly lower than the national average of 2.6 (Figure 8).

Figure 8. Number of Hospital Beds per 1,000 Population, 2012



Source: 1999–2013 American Hospital Association (AHA) Annual Survey, 2015, from Kaiser Family Foundation. Total Hospitals, State Health Facts. See All Ages: Table 5 in Appendix B.

24-Hour Beds Available for Behavioral Health Treatment

Rhode Island has a total of 1,345 beds available for 24-hour behavioral health treatment as of 2015.³⁶ Table 6 shows the number of these beds for each behavioral health treatment setting.

Table 6. Number of 24-Hour Beds Available for Behavioral Health Treatment in Rhode Island, 2015

Setting	Beds
Hospital Inpatient	535
Hospital Sub-Acute	29
Residential Mental Health	383
Residential Substance Use	316
Detoxification	82
TOTAL	1,345

Source: BHDDH via personal communication on June 2nd, 2015.

³⁶ Source: BHDDH via personal communication on June 2, 2015.

Community Support Services

Various types of services are effective at helping individuals with mental and substance use disorders stay in the community and out of expensive hospital and institutionalized settings. These include Assertive Community Treatment (ACT), timely post-discharge hospital follow-up, partial hospitalization, crisis intervention, peer support, 24-hour crisis stabilization beds, short-term residential crisis services, housing support, and crisis intervention teams.³⁷

Table 7 describes specific behavioral health support services supplied in Rhode Island. We discuss these services in more detail below.

Table 7. Number of Behavioral Health Community Support Services in Rhode Island, 2010–2014

Service	2010	2011	2012	2013	2014
Substance abuse recovery centers	1	1	2	2	2
Peer-run centers	2	2	2	2	2
Clubhouses	1	2	2	2	2
Recovery housing beds	N/A	N/A	N/A	450	373
Recovery coaches ^a	0	0	N/A ^b		
Peer recovery specialists ^c	0	0	18	N/A	63
Assertive Community Treatment	N/A	8.5% of consumers with SMI	0	0	N/A
Mobile Treatment Teams	N/A	N/A	N/A	N/A	16

Abbreviations: BHDDH, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals; N/A, not available

^a Trained by Anchor but not necessarily certified

^b Approximately 100 trained each year; exact numbers unavailable

^c Certified by BHDDH

Source: BHDDH via personal communication on 1/26/2015; CMHS Uniform Reporting System (URS) Output Tables

Assertive Community Treatment Teams

In the fall of 2011, Rhode Island discontinued Assertive Community Treatment teams and instead implemented the Rhode Island Consumer System of Care (RISOC). Although RISOC provides a coordinated team approach to treatment for consumers with serious mental illness,

³⁷ Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration. <http://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

it has less stringent requirements than ACT with regard to treatment hours and client to staff ratios, which may reduce its effectiveness.

Housing Assistance

For individuals with behavioral health conditions, negative effects of the illness can create unstable housing conditions or even result in loss of a home. Having a safe and secure place to live is an important part of recovery, in addition to access to services that enable those with behavioral health conditions to live as independently as possible.³⁸

Only 2.6 percent of individuals with serious mental illness served by the Rhode Island mental health system received supportive housing (compared with an average of 2.8 percent nationally). Moreover, the rate of homelessness among those served by the Rhode Island mental health system was higher than the national average (5 percent versus 3.3 percent).

In 2014, the Rhode Island Department of Veterans Affairs issued 151 housing vouchers related to behavioral health, which was an increase from the 135 issued in 2010. *Housing First* (Riverwood Mental Health Services) issued 49 housing vouchers in 2014—a decline from the 68 issues in 2012. Additionally, *Providence Center's Home Base Program* housed 4 individuals in 2011, 50 in 2012, 26 in 2013, and 56 in 2014. Overall, Rhode Island Housing supplied 1,700 general certificates and vouchers in 2013. Additional information about housing vouchers in Rhode Island can be found in Appendix B, All Ages: Table 9.

Post-Discharge Follow-up

In 2013, Rhode Island's Medicaid managed care plans had a mental health post-discharge follow-up rate of 64.2 percent in 7 days and 81.3 percent in 30 days. This was below the Health Effectiveness Data and Information Set (HEDIS) 90th percentile but above the mean of all states reporting.

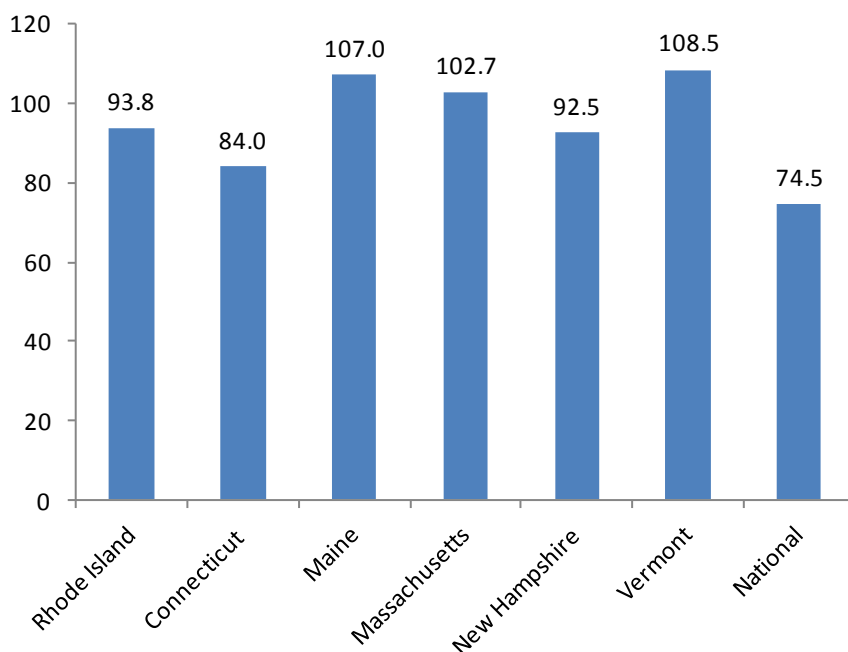
³⁸ Source: Mental Health America, Housing. <http://www.mentalhealthamerica.net/housing>. Accessed May 2, 2015.

Physicians and other Health Professionals

Primary Care Physicians

In 2012, there were 985 primary care physicians in Rhode Island, which was an increase from 942 in 2010.³⁹ Rhode Island averaged 91.3 primary care physicians per 100,000 population between 2010 and 2012. This per capita rate fell within the range across New England states and was higher than the national average (Figure 9). According to criteria established by the Federal Health Resources and Services Administration, Rhode Island does not have a shortage of primary medical care professionals.⁴⁰

Figure 9. Number of Primary Care Physicians per 100,000 Population, 2012



Source: Area Health Resource Files. Derived from census population estimates for 2010, 2011, and 2012. See All Ages: Table 1 in Appendix B.

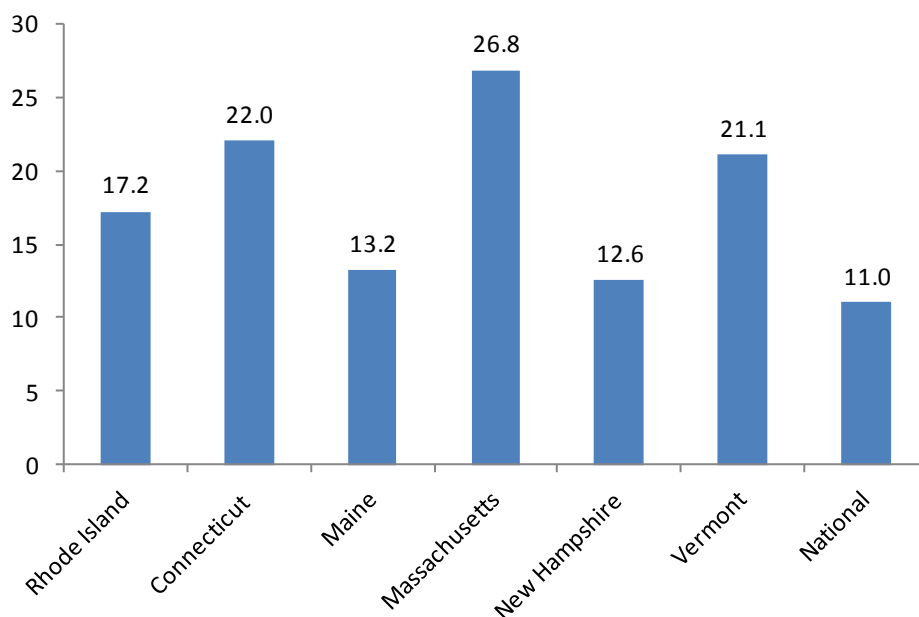
³⁹ *Primary care* includes general family medicine, general practice, general internal medicine, and general pediatrics. Subspecialties within these specialties were excluded.

⁴⁰ The Federal Health Resources and Services Administration designates a shortage area if the area has a population to full-time-equivalent primary care physician ratio of at least 3,500:1. Rhode Island has a ratio of approximately 3.3 total patient care primary care physicians per 3,500 population, thus indicating that it does not have a shortage of primary care physicians.

Psychiatrists

Rhode Island had 181 total psychiatrists responsible for patient care in 2012, which was similar to the 183 psychiatrists the state had in 2010.⁴¹ On average, the number of psychiatrists per 100,000 population in Rhode Island fell within the range across New England states and was higher than national average. According to the criteria used by the Federal Health Resources and Services Administration, Rhode Island does not have a shortage of psychiatrists (Figure 10).⁴²

Figure 10. Number of Psychiatrists per 100,000 Population, 2012



Source: Area Health Resources Files; derived from census population estimates for 2010, 2011, and 2012. See All Ages: Table 2 in Appendix B.

Psychologists

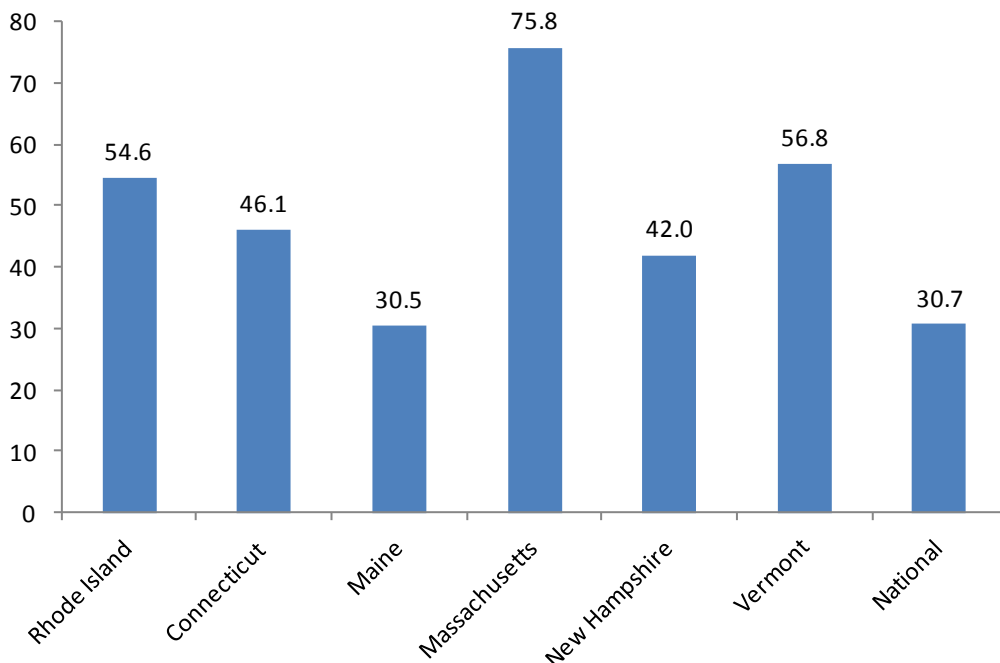
⁴¹ *Hospital full-time staff* includes physicians employed under contract with hospitals to provide direct patient care and excludes hospital residents.

⁴² Rhode Island had roughly 30,000:5 psychiatrists in the years 2010–2012, which is not a shortage based on Health Resources and Services Administration (HRSA) standards. HRSA guidelines will designate a shortage area if there is a population-to-psychiatrist ratio greater than or equal to 30,000:1. In areas where there is an unusually high need for mental health services, a shortage designation would be considered when a population-to-psychiatrist ratio is greater than or equal to 20,000. Source: HRSA. Mental Health, Health Professionals Shortage Area (HPSA) Designation Criteria. HRSA website.

<http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsacriteria.html>. Accessed April 12, 2015.

In 2011, Rhode Island had 573 psychologists, which translates to 54.6 psychologists per 100,000 population. The number of psychologists per capita in Rhode Island fell within the range of neighboring states and was higher than the national average (Figure 11).

Figure 11. Number of Psychologists per 100,000 Population, 2011



Source: Association and membership certification data from Substance Abuse and Mental Health Services Administration, Behavioral Health, United States, 2012. See All Ages: Table 4 in Appendix B.

Clinical Social Workers

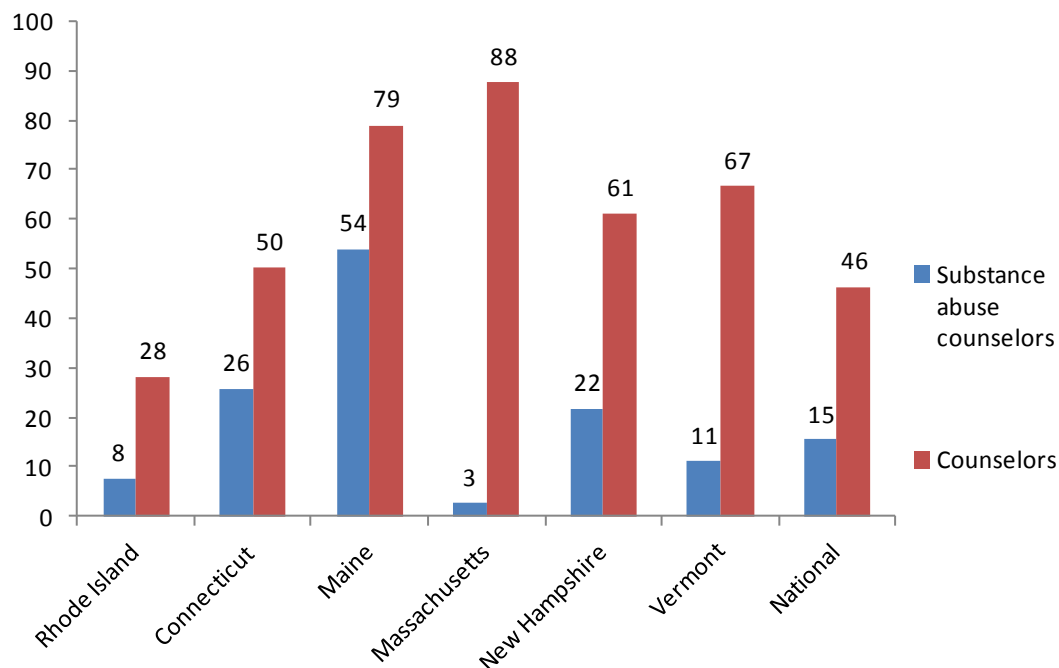
In 2011, Rhode Island had 1,721 clinical social workers. There were 163.9 clinical social workers per 100,000 population in Rhode Island, which fell within the range of neighboring states and was significantly higher than national average (data not shown in figures).

Substance Abuse Counselors

In 2011, Rhode Island had 80 substance abuse counselors and 296 behavioral health counselors (i.e., those who treat both mental and substance use disorders). The number of substance abuse counselors and behavioral health counselors per 100,000 population in Rhode Island was lower than the national average (Figure 12). This ratio was the lowest of all New England states

for behavioral health counselors and second lowest for substance abuse counselors. However, it is important to note that counseling is provided by other types of professionals (e.g., clinical social workers) in the state.

Figure 12. Percentage of Substance Abuse Counselors and Behavioral Health Counselors, per 100,000 Population, 2011



Source: Association and membership certification data from Substance Abuse and Mental Health Services Administration, Behavioral Health, United States, 2012. See All Ages: Table 4 in Appendix B.

Mental Health Professionals in Community Health Centers

Of the five geographic catchments in Rhode Island, three are designated as having at least one community health center with a shortage of mental health professionals.⁴³ As of April 2015, the numbers of facilities were the following: Newport County (1), Providence County (6), and

⁴³ Mental health professional shortage areas are calculated by applying a score to each county based on a population-to-provider ratio, percentage of individuals below 100% of the federal poverty level, youth ratio (ratio of children under 18 to adults ages 18–64), elderly ratio (ratio of adults over 65 to adults ages 18–64), substance abuse prevalence, alcohol abuse prevalence, and average travel time or distance to nearest source of nondesignated accessible care. Source: Health Resources and Services Administration, Mental Health HPSA Designation Criteria. <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsacriteria.html>. Accessed April 12, 2015.

Washington County (1).⁴⁴ A community health center displays a shortage of psychiatric professionals if the facility is providing (or is responsible for providing) mental health services to an area or population group designated as having a mental health professional shortage and the facility has insufficient capacity to meet the psychiatric needs of the area or population group.⁴⁵

Specialty Facilities for Treatment of Substance Use Disorders

As noted earlier, adults in Rhode Island had a higher prevalence of substance use disorders, higher age-adjusted death rates from narcotics and hallucinogens, and higher reported unmet need for substance use treatment.

Rhode Island Specialty Substance Abuse Facilities

According to SAMHSA's National Survey on Substance Abuse Treatment Services (N-SSATS), in 2012 Rhode Island had 63 specialty substance abuse facilities (an increase from 53 in 2010). These include 56 outpatient facilities (52 facilities that provide regular substance abuse outpatient treatment, 31 that provide intensive outpatient, 9 that provide day treatment or partial hospitalization, 16 that provide detoxification, and 15 that provide methadone maintenance); 16 residential substance abuse facilities (8 short-term, 15 long-term, and 2 detoxification); and 4 hospital inpatient facilities (4 offering treatment, and 3 offering detoxification). According to the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), Rhode Island has 24 BHDDH-licensed agencies to provide substance abuse treatment services.⁴⁶

The one day census of clients in substance use disorder treatment facilities in Rhode Island was 7,362 in 2010, 9,742 in 2011, and 8,499 in 2012. The per capita rate of clients in treatment in

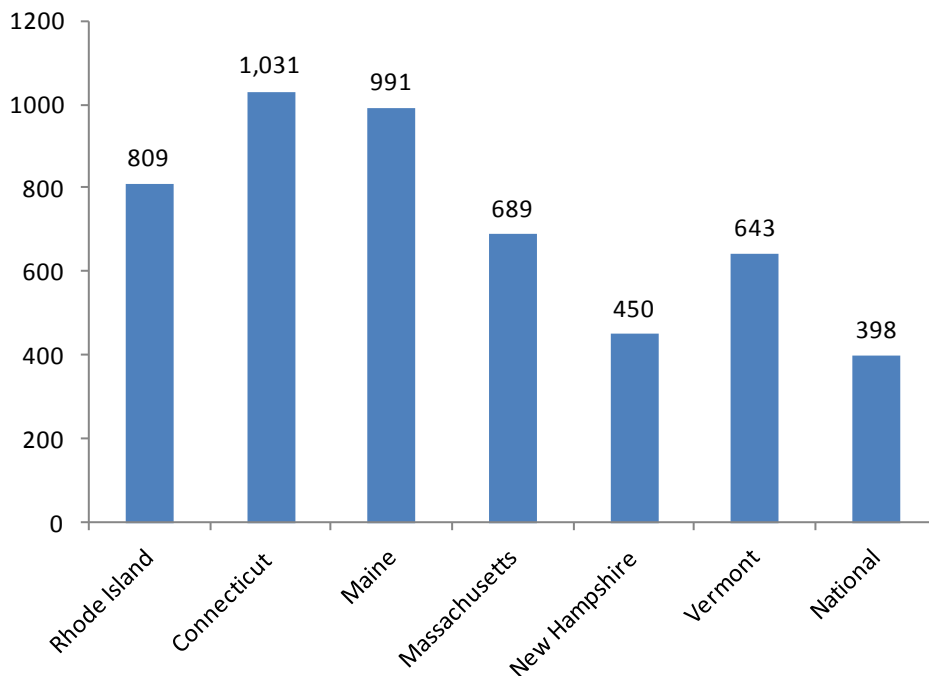
⁴⁴ U.S. Department of Health and Human Services. Health Resources and Services Administration. 2015. Find Shortage Areas: HPSA by State and County. <http://hpsafind.hrsa.gov/>. Accessed April 15, 2015.

⁴⁵ A facility is considered to have insufficient capacity to meet the mental health service needs of the area or population it serves if one of the following apply: (1) there are more than 1,000 patient visits per year per full-time equivalent (FTE) core mental health professionals on staff of the facility, (2) there are more than 3,000 patient visits per year per FTE psychiatrist on staff of the facility, or (3) no psychiatrists are on the staff and the facility is the only facility providing (or responsible for providing) mental health services to the designated area or population. Source: Health Resources and Services Administration, Mental Health HPSA Designation Criteria. <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsacriteria.html>. Accessed April 12, 2015.

⁴⁶ Department of BHDDH Division of Behavioral Healthcare. Agencies Licensed to Provide Substance Abuse Treatment Services. Last updated January 5, 2015. http://www.bhddh.ri.gov/SA/pdf/BHDDH-Licensed%20Substance%20Abuse%20Agencies%20for%20External%20Database%20%28revised%201-5-15%29_1.pdf?513. Accessed April 15, 2015.

specialty substance facilities fell within the range of New England states but was higher than the national average (Figure 13).

Figure 13. Number of Clients with Substance Use Disorders in Specialty Substance Use Disorder Treatment Facilities per 100,000 Population, One Day Measurement, 2012



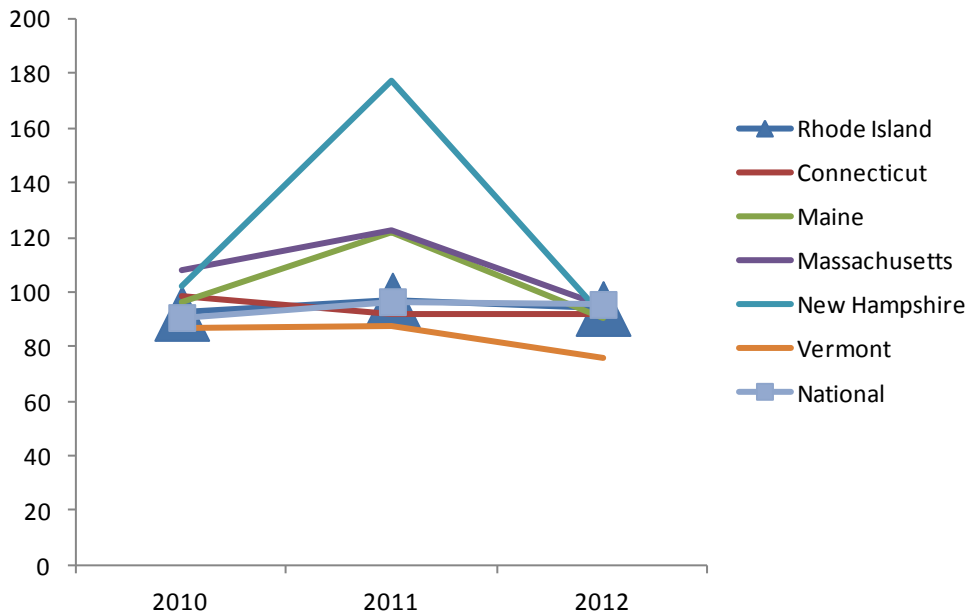
Source: National Survey on Substance Abuse Treatment Services (N-SSATS). See All Ages: Table 7 in Appendix B.
Note: Clients in treatment were measured using a one-day census on March 31, 2012.

Residential Treatment Facility Utilization for Substance Use Disorders

Residential treatment facility utilization for substance use disorders in Rhode Island remained relatively constant during 2010–2012 (92.3, 97.2, and 94.1 percent, respectively).⁴⁷ These percentages fell within the middle of the range of facility utilization for other New England States and were similar to the national averages (Figure 14).

⁴⁷ The N-SSATS asked facilities to report the number of residential and hospital inpatient beds designated for substance abuse treatment. Utilization rates were calculated by dividing the number of residential or hospital inpatient clients by the number of residential or hospital inpatient designated beds. Utilization rates could be more than 100 percent, because clients with substance use disorders also may occupy nondesignated beds.

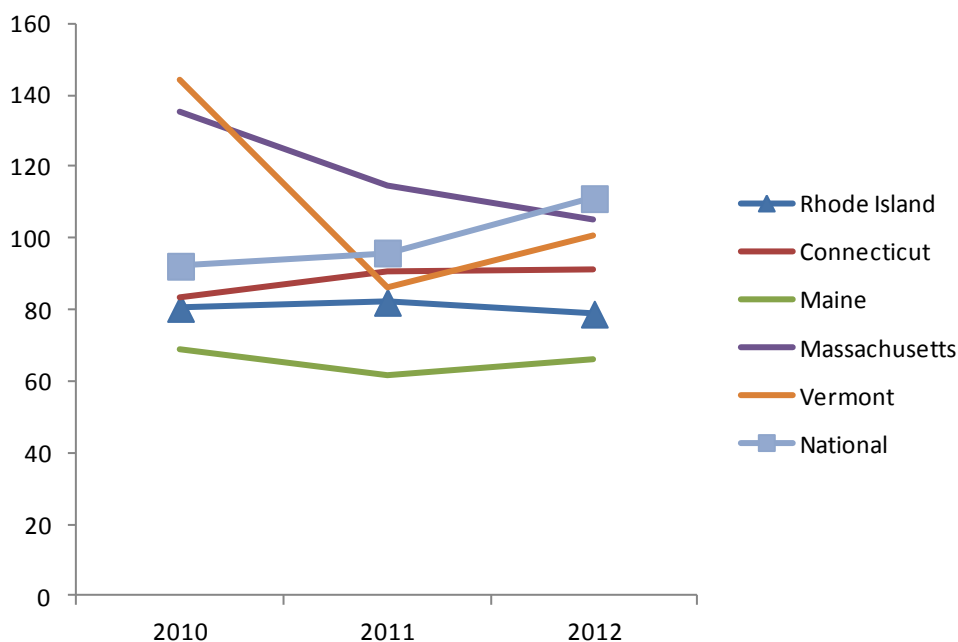
Figure 14. Residential Treatment Facility Utilization Rate for Substance Use Disorders, 2010–2012



Source: The National Survey on Substance Abuse Treatment Services (N-SSATS). See All Ages: Table 12 in Appendix B.

The hospital facility utilization rate for treatment of substance use disorders remained relatively constant during 2010–2012, falling just slightly from 80.4 percent in 2010 to 78.8 percent in 2012 (Figure 15). As with the residential treatment facility utilization rate, the utilization rate for substance use disorder treatment in hospital facilities in Rhode Island fell in the middle of the range of other New England states. However, this rate was lower than national averages across all 3 years.

Figure 15. Hospital Treatment Facility Utilization Rate for Substance Use Disorders, 2010–2012



Source: The National Survey on Substance Abuse Treatment Services (N-SSATS). See All Ages: Table 12 in Appendix B.

Supply of Medication Assisted Therapy

Medications are an important aspect of treatment for substance use disorders. Medications to treat opioid addiction include buprenorphine, naltrexone, and methadone. Medications to treat alcohol use disorders include naltrexone, disulfiram, and acamprosate.

Physicians with Buprenorphine Waivers and Availability of Buprenorphine

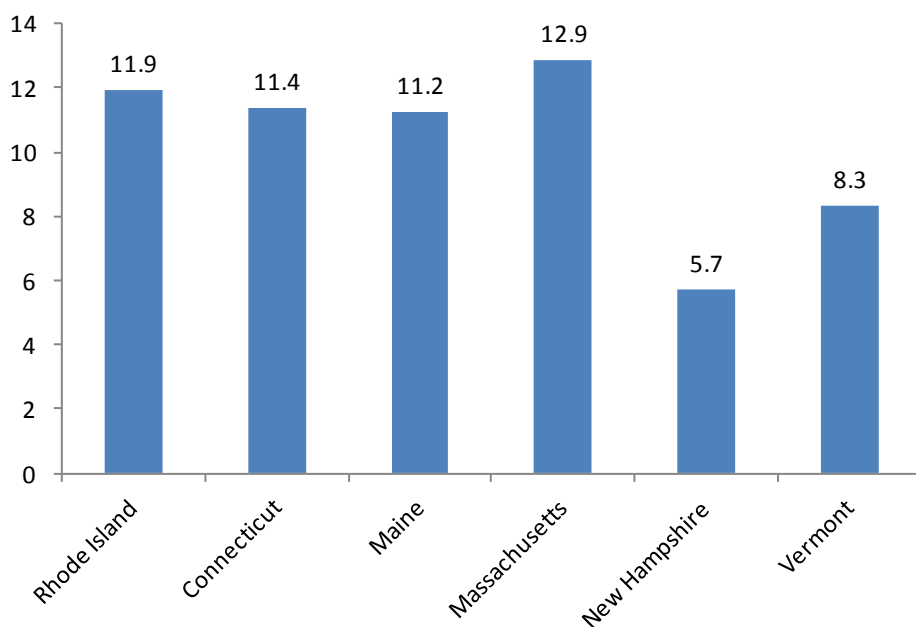
As a result of the Drug Addiction Treatment Act of 2000, physicians must receive a waiver through the special registration requirements in the Controlled Substances Act in order to prescribe buprenorphine. As of 2015, Rhode Island has 100 physicians authorized to treat opioid addiction with buprenorphine.⁴⁸ The state has 11.9 authorized physicians per 100,000 adults, which is the second-highest number among New England states (Figure 16). It should be

⁴⁸ Source: Substance Abuse and Mental Health Services Administration. Buprenorphine Physician and Treatment Program Locator. SAMHSA website. http://buprenorphine.samhsa.gov/bwns_locator/. Accessed February 19, 2015. Totals per 100,000 adults were derived from population estimates from census.gov as of July 1, 2013 for adults aged 18 years and older.

noted that the fact that a physician has received a waiver to prescribe buprenorphine does not mean that he or she is actually prescribing it.

Rhode Island has 21 buprenorphine treatment programs (2.5 buprenorphine treatment programs per 100,000 adults), which also is the second highest of the New England states.

Figure 16. Number of Physicians Authorized to Dispense Buprenorphine per 100,000 Adults, 2015



Source: Substance Abuse and Mental Health Services Administration. Buprenorphine Physician and Treatment Program Locator. SAMHSA website. http://buprenorphine.samhsa.gov/bwns_locator/. Accessed February 19, 2015. Totals per 100,000 adults were derived from population estimates from census.gov as of July 1, 2013 for adults aged 18 years and older. See Ages 18+: Table 1 in Appendix B.

As mentioned, physicians receiving a waiver to prescribe buprenorphine may not be actively prescribing buprenorphine. This could create an access barrier for patients in need, particularly if the physicians who are prescribing buprenorphine are geographically mismatched to the areas with greatest need. In 2014, the Rhode Island General Assembly passed a bill requiring all health insurance to provide coverage for drugs which treat opioid substance use and addictions. Geographically, RI is a small state and opioid treatment programs are dispersed in all counties, with the exception of Bristol.⁴⁹

⁴⁹ Source: BHDDH via personal communication on May 26th, 2015.

Table 8 contains data on emergency department visits with a primary diagnosis of opioid overdose, by age group, in Rhode Island for years 2010-2013 and illustrates the increased impact of opioid use on Rhode Islanders. The number of emergency department visits with a primary diagnosis of opioid overdose doubled from 2009 to 2013,⁵⁰ with notable increases in certain age groups. There was an 80% increase from 2012 to 2013 in the age 0-19 category and a 32% increase in the 20-24 year-olds. These numbers heighten Rhode Island’s concern for the future and point to a need for targeted prevention and treatment interventions.⁵¹

Table 8. Rhode Island Emergency Department Visits with a Primary Diagnosis of Opioid Overdose, 2010-2013

Year	Age Group												Total		
	0-19	% Change	20-24	% Change	25-34	% Change	35-44	% Change	45-54	% Change	55-64	% Change		65+	% Change
2010	24	-31%	94	-5%	207	24%	149	10%	123	10%	43	-17%	4	-43%	644
2011	30	25%	131	39%	268	29%	185	24%	134	9%	45	5%	14	250%	808
2012	20	-33%	175	34%	346	29%	228	23%	139	4%	72	60%	14	0%	995
2013	36	80%	231	32%	433	25%	254	11%	174	25%	80	11%	20	43%	1230
Total	250		1001		2100		1584		1091		419		88		6533

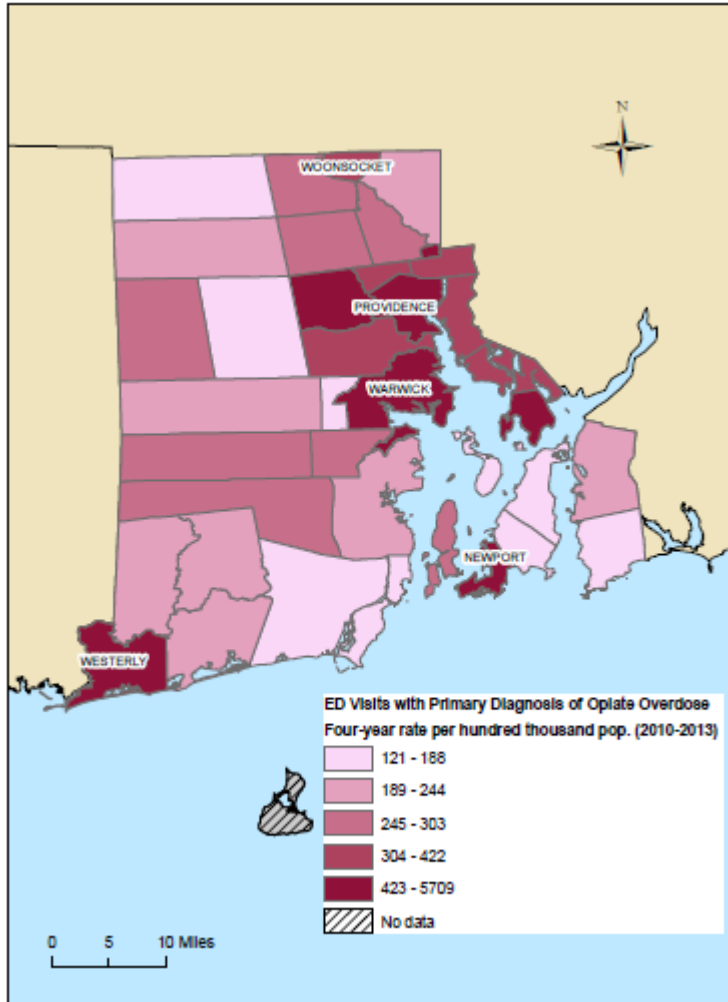
Source: Rhode Island Department of Health

Figure 17 displays emergency department visits related to a primary diagnosis of opiate overdose by geographic area in Rhode Island for the years 2010–2013, and Table 8 contains data on emergency department visits with a primary diagnosis of opioid overdose, by age group, in Rhode Island for years 2010-2013.

⁵⁰ Source: BHDDH via personal communication on May 26th, 2015.

⁵¹ Ibid.

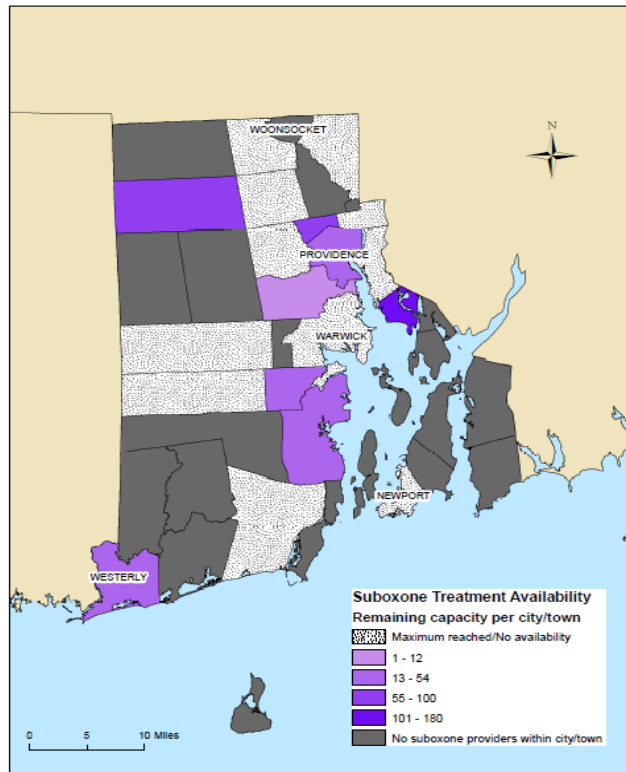
Figure 17. Emergency Department Visits with Primary Diagnosis of Opiate Overdose, 4-Year Rate per 100,000 Population, 2010–2013.



Source: BHDDH via personal communication, May 26, 2015.

Figure 18 depicts geographic buprenorphine availability in Rhode Island. In some communities, prescribing doctors are either non-existent or are not accepting new patients. Furthermore, eight of the highest-risk communities have no access to buprenorphine treatment.

Figure 18. Geographic Buprenorphine Availability in Rhode Island, 2010–2013.



Source: BHDDH via personal communication, May 26, 2015.

Some physicians with waivers have limited their practices and are not accepting patients up to the 100 cap.⁵² Rhode Island also currently lacks the infrastructure to provide real-time access to availability of buprenorphine treatment.⁵³ It is difficult to obtain information about which physicians provide buprenorphine, which physicians have open capacity, and what insurances are accepted by these physicians.

The increase of opioid medication prescribing across the country has significantly raised rates of opioid addiction in many states, and successful implementation of Prescription Drug Monitoring Programs (PDMPs) has contributed to a rapid increase in rates of primary heroin dependence as people have lost access to their supply of prescription medications. In Rhode Island, increased opioid prescribing and implementation of the PDMP has only exacerbated the long-standing heroin problem.⁵⁴

⁵² Source: BHDDH, via personal communication on May 26^h, 2015.

⁵³ Ibid.

⁵⁴ Ibid.

Table 9 presents data from Rhode Island’s Behavioral Healthcare On-line data system (BHOLD). Admissions to treatment for heroin have grown steadily since 2011 and significantly in 2014. Admissions for other opiates (prescription opioids) rose steadily until 2013, with slight decreases since that time, most likely related to implementation of the PDMP.

Table 9. Number of Admissions to Treatment, by Primary Substance, Rhode Island, Years 2010-2015

Substance	2010	2011	2012	2013	2014	2015	Grand Total
Alcohol	4755	4698	4868	4892	4621	3342	27973
Benzodiazepines	90	90	113	125	104	71	601
Cocaine	1081	956	915	886	902	537	5533
Heroin	2567	2351	2766	3483	4359	3059	19156
Marijuana	1919	1729	1574	1372	1162	689	8932
Methadone	27	39	38	47	42	26	225
Other amphetamine	8	11	22	22	34	26	126
Other opiate	787	939	1334	1215	1132	679	6273

Source: BHOLD.

Note: The 2015 data is incomplete at the time of this report.

Medicaid Coverage of Medication to Treat Substance Use Disorder

As of 2013, Rhode Island Medicaid covered buprenorphine, methadone, naltrexone, disulfiram, and acamprosate. It did not cover extended-release naltrexone (Vivitrol®).⁵⁵

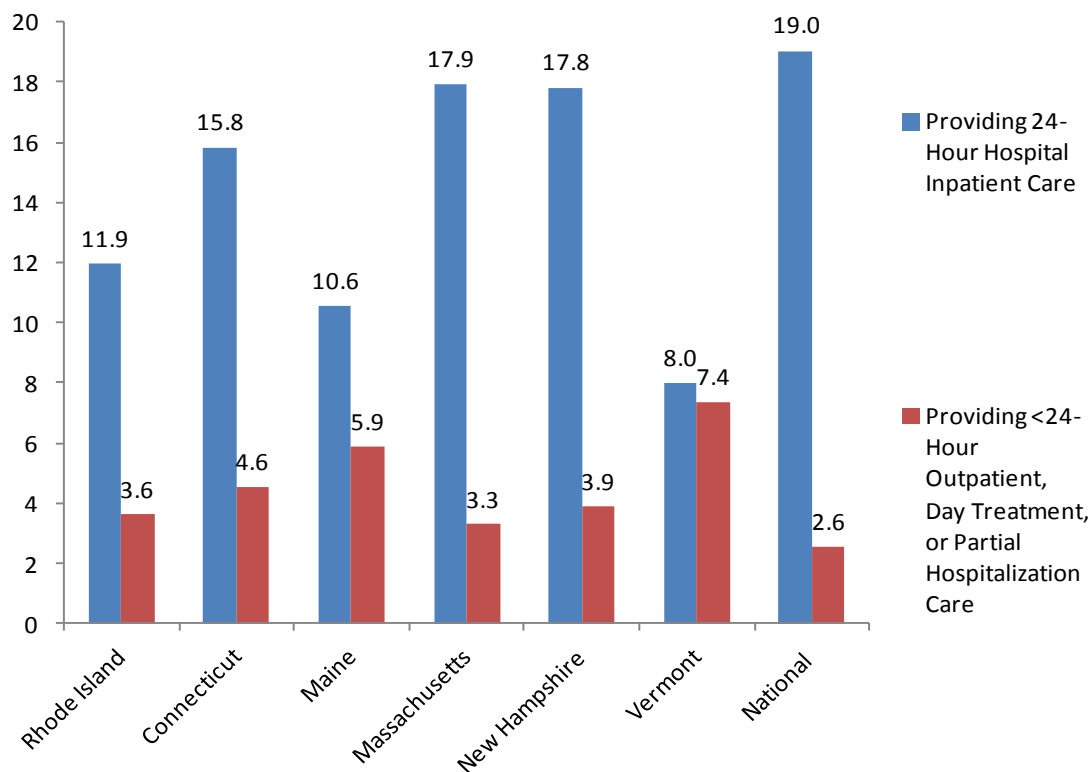
Specialty Facilities for Mental Health Services

In 2010, Rhode Island had 11.9 mental health facilities providing 24-hour hospital inpatient care per 100,000 population, which was in the middle of the range for New England States but lower than the national average (Figure 19). Rhode Island also had 3.6 mental health facilities providing less than 24-hour outpatient, day treatment, or partial hospitalization per 100,000 population, which also fell in the middle of the range for New England states and was higher than the national average.

⁵⁵ Substance Abuse and Mental Health Services Administration. Medicaid Coverage and Financing of Medications to Treat Alcohol and Opioid Use Disorders. HHS Publication No. SMA-14-4854. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2014. <http://store.samhsa.gov/product/Medicaid-Coverage-and-Financing-of-Medications-to-Treat-Alcohol-and-Opioid-Use-Disorders/SMA14-4854>

More recent survey data should be assessed when they become available, because Rhode Island has had shifts in treatment design since 2010. For 2015 Rhode Island data on the number of 24-hour beds by hospital and residential settings, please refer to the *Hospitals* section found earlier in the report.

Figure 19. Number of Mental Health Facilities per 100,000 Population by Type of Care, 2010



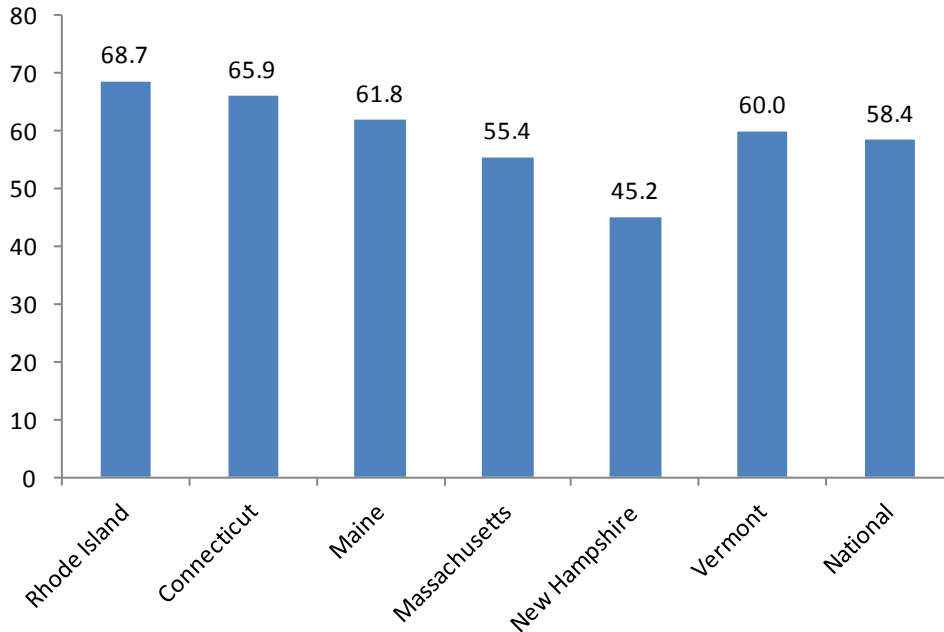
Source: The National Survey on Substance Abuse Treatment Services (N-SSATS). See All Ages: Table 14 in Appendix B

Note: More recent survey data should be assessed when they become available, because Rhode Island has had shifts in treatment design since 2010.

Mental Health Facilities with Programs for Co-occurring Mental and Substance Use Disorders

In 2010, 68.7 percent of Rhode Island’s mental health facilities had programs specifically designed for individuals with co-occurring mental and substance use disorders. This percentage was the highest among New England states and higher than the national average (Figure 20). More recent survey data should be assessed when they become available, because Rhode Island has had shifts in treatment design since 2010.

Figure 20. Percentage of Total Mental Health Facilities Offering Treatment Programs Specifically for Individuals With Co-occurring Mental and Substance Use Disorders, 2010



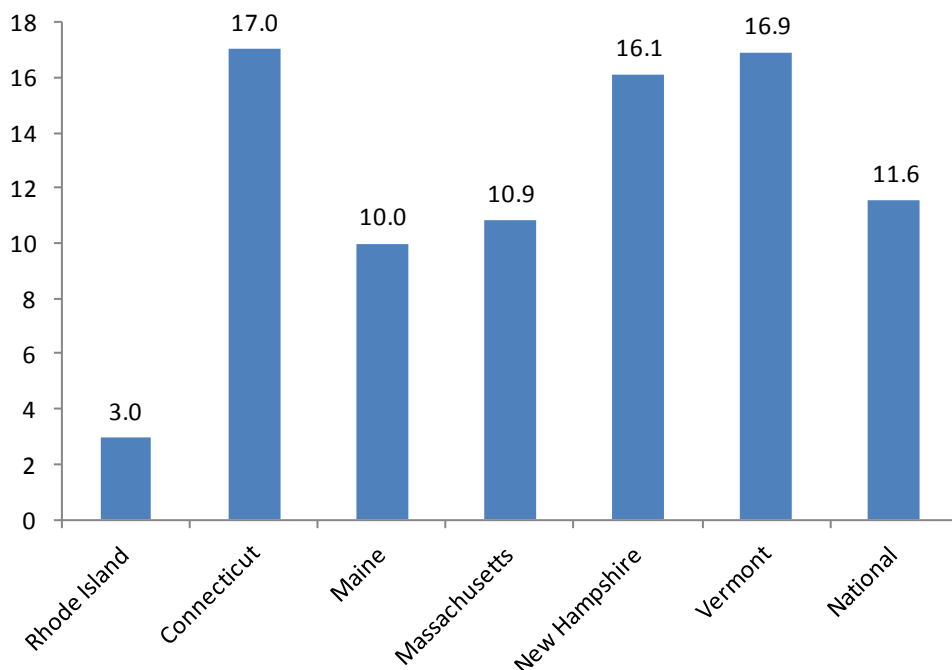
Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2010 National Mental Health Services Survey (N-MHSS). See All Ages: Table 18 in Appendix B. Note: More recent survey data should be assessed when they become available, because Rhode Island has had shifts in treatment design since 2010.

Mental Health Facilities with Programs for Individuals with Traumatic Brain Injury

Rhode Island had a significantly lower percentage of facilities with programs specifically for individuals with traumatic brain injury (3.7 percent) among New England states. Rhode Island also had a lower percentage of these facilities than the national average (Figure 21). This is a concern because Rhode Island has an extremely high proportion of redeployed National Guard and Reservists who served in the Gulf Wars.⁵⁶ More recent survey data should be assessed when they become available, because Rhode Island has had shifts in treatment design since 2010.

⁵⁶ Source: BHDDH via personal communication on June 1, 2015.

Figure 21. Percentage of Total Mental Health Facilities Offering Treatment Programs Specifically for Individuals with Traumatic Brain Injury, 2010

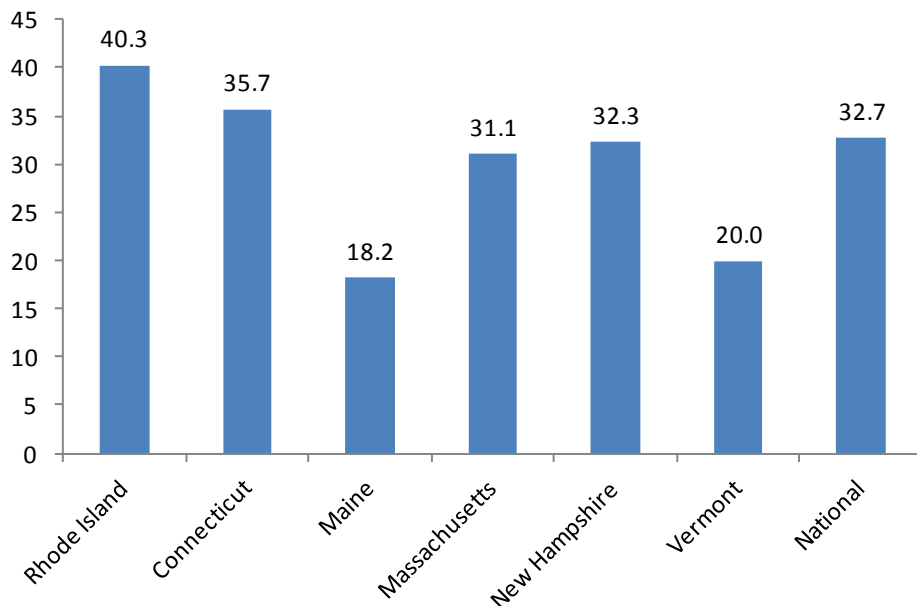


Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2010 National Mental Health Services Survey (N-MHSS). See All Ages: Table 18 in Appendix B. Note: More recent survey data should be assessed when they become available, because Rhode Island has had shifts in treatment design since 2010.

Mental Health Facilities with Programs for Forensic Clients

Rhode Island had the highest percentage of mental health facilities with programs specifically designed for forensic clients (40.3 percent) among New England states. Rhode Island also had a higher percentage of these facilities than the national average (Figure 22). More recent survey data should be assessed when they become available, because Rhode Island has had an increase in forensic patients in the system in the past few years.

Figure 22. Percentage of Total Mental Health Facilities Offering Treatment Programs Specifically for Forensic Clients, 2010



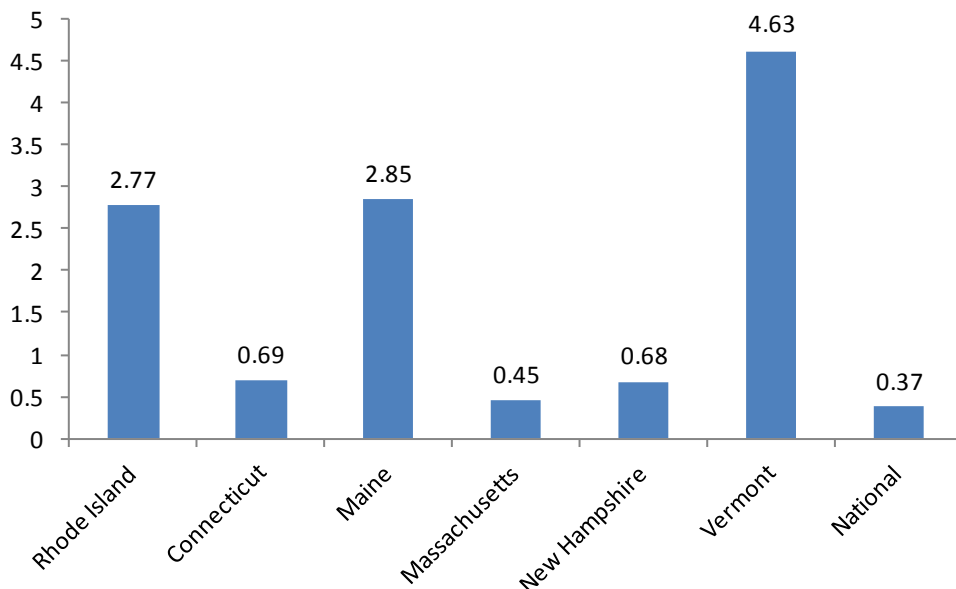
Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2010 National Mental Health Services Survey (N-MHSS). See All Ages: Table 18 in Appendix B.

Note: More recent survey data should be assessed when they become available, because Rhode Island has had an increase in forensic patients in the system in the past few years.

Residential Treatment Programs

In 2010, Rhode Island had 2.8 adult residential mental health treatment programs per 100,000 adults. This number was in the middle of the range for New England states and higher than the national average (Figure 23). Please refer to the *Hospitals* section earlier in this report for the number of 24-hour residential treatment beds in Rhode Island as of 2015.

Figure 23. Number of Mental Health Residential Treatment Programs for Adults per 100,000 Adults, 2010



Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. National Mental Health Services Survey (N-MHSS), 2010. See Ages 18+: Table 5 in Appendix B.

Note: More recent survey data should be assessed when they become available, because Rhode Island has had shifts in treatment design since 2010.

Programs for Individuals with Alzheimer's Disease or Dementia

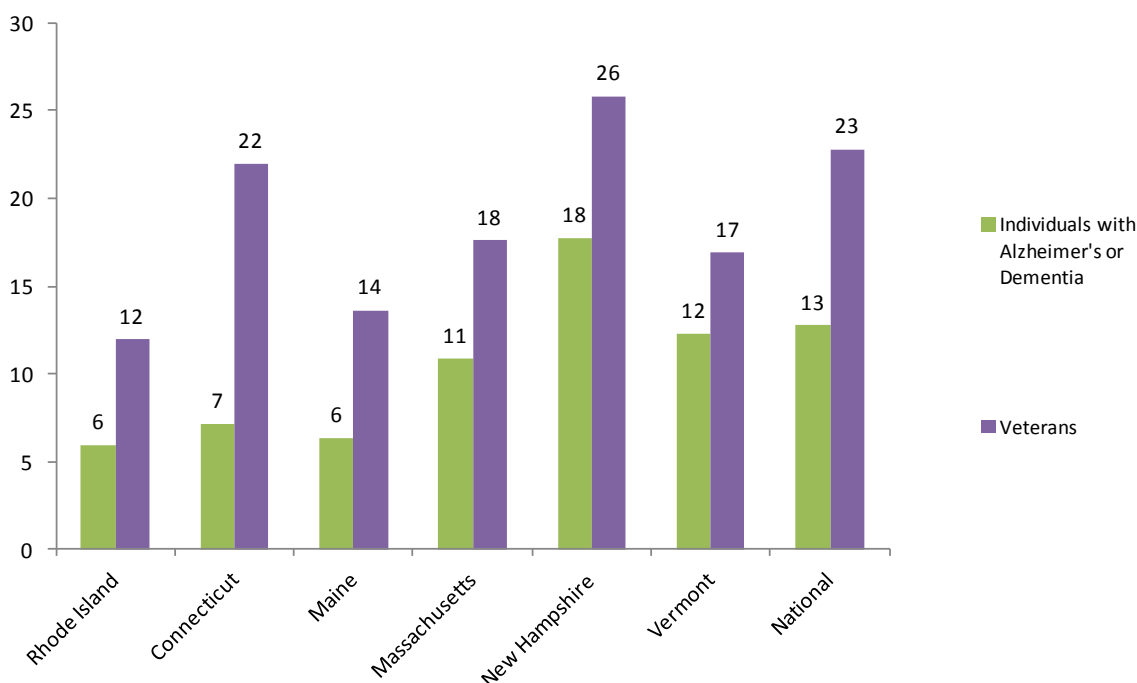
In 2010, 6.0 percent of all mental health facilities in Rhode Island had programs for individuals with Alzheimer's disease or dementia, which was the lowest percentage in the New England states and was lower than the national average (Figure 24). Among the older adult age groups, Rhode Island had the highest prevalence of frequent mental distress of all New England states. The small number of programs for individuals with mental disorders typically found in older adults may indicate an unmet need for some populations. More recent survey data should be assessed when they become available, because Rhode Island has had shifts in treatment design since 2010.

Programs for Veterans

In 2010, 11.9 percent of all mental health facilities in Rhode Island had programs specifically designed for veterans. This percentage was the lowest of the New England states and was

lower than the national average (Figure 24). More recent survey data should be assessed when they become available, because Rhode Island has had shifts in treatment design since 2010.

Figure 24. Percentage of Total Mental Health Facilities Offering Treatment Programs Exclusively Designed for Specific Adult Groups, 2010



Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. National Mental Health Services Survey (N-MHSS), 2010. See Ages 18+: Table 6 in Appendix B.

Note: More recent survey data should be assessed when they become available, because Rhode Island has had shifts in treatment design since 2010.

Mental Health Psychiatric Rehabilitative Residences

In Rhode Island, Mental Health Psychiatric Rehabilitative Residences (MHPRRs) are facilities that provide long-term care. Patients accepted for admission must qualify for a group home level of care. To be considered for placement in an MHPRR, a person must be (1) aged 18 years or older and not under the jurisdiction of the Department of Children, Youth & Families; (2) diagnosed with a serious and persistent mental illness (i.e., meet the eligibility criteria for treatment in a community support program), and (3) unable to receive care in a less restrictive community setting because of serious and persistent mental illness.⁵⁷ When the treatment

⁵⁷ Source: BHDDH via personal communication on June 1, 2015.

team determines that patients no longer qualify for this level of services, discharge to a less restrictive environment becomes mandatory under federal guidelines.⁵⁸

In 2015, Rhode Island has 10 MHPRRs in a total of 32 locations with a total of 381 beds. These 10 MHPRRs are part of the 28 total Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals licensed Mental Health and Addiction Agency Programs; the remaining 18 programs are addiction agencies.⁵⁹ More details about the MHPRRs in Rhode Island in 2015 are contained in Appendix B, 18+ Table 8.

Evidence-Based Practices

Evidence-Based Practices (EBP) for behavioral health treatment are a critical component in a state’s behavioral health treatment framework. Many EBP treatment services provide management of behavioral health disorders in a community setting, thus preventing avoidable hospitalizations, cutting down on treatment costs, and boosting a patient’s quality of life. Table 10 displays key EBP rates for Rhode Island and nationally.

Rhode Island does not have Assertive Community Treatment or Family Psychoeducation available, and the state should consider incorporating these practices into its behavioral health treatment framework.

Table 10. Percentages of Key Evidenced-Based Practices, Rhode Island and US Average, 2013.

Measures	Rhode Island	US Average
Assertive Community Treatment	-	2.0
Family Psychoeducation	-	1.3
Supportive Employment	5.4	1.9
Integrated Dual Diagnosis Treatment	19.6	3.7
Supported Housing	2.6	2.8

Source: SAMHSA, 2015. Accessed at <http://www.samhsa.gov/data/sites/default/files/URSTables2013/RhodeIsland.pdf> on 6/11/15.

⁵⁸ Source: BHDDH Application for Admission. May 2012.
<http://www.bhddh.ri.gov/MH/pdf/Group%20Home%20Application%20For%20Admission%2005-23-12.pdf>.
Accessed March 25, 2015.

⁵⁹ Source: BHDDH, 2012.

Summary

Analyses of data for individuals of all ages indicated the following primary results:

- The numbers of primary care physicians, psychiatrists, and psychologists per capita in Rhode Island fell within the ranges of numbers for other New England states and were higher than the national averages.
- The numbers of substance abuse counselors and behavioral health counselors (i.e., those who treat both mental and substance use disorders) per capita were lower than the national average. Rhode Island ranked lowest of all New England states for behavioral health counselors and second lowest for substance abuse counselors, though other professionals provide counseling in the state (e.g., clinical social workers).
- The total number of general hospital beds per capita in Rhode Island was similar to other New England states and slightly lower than the national average.
- After 2011, Rhode Island had no Assertive Community Treatment programs.
- The rate of homelessness among those served by the Rhode Island mental health system was higher than the national average (5% versus 3.3%), though only 2.6 percent of individuals with serious mental illness served by the Rhode Island mental health system received supportive housing.
- Among Rhode Island Medicaid beneficiaries who were hospitalized for a mental illness, one in five had no follow-up mental health treatment in 30 days.
- Rhode Island had no mental health programs offering specialized services for traumatic brain injury.
- Of the five counties in Rhode Island, three are designated as having at least one community health center with a shortage of mental health professionals: Newport County (1), Providence County (6), and Washington County (1).
- Rhode Island had no mental health programs offering specialized services for traumatic brain injury. It had the lowest percent of mental health facilities offering programs specifically designed for Veterans or for individuals with Alzheimer’s disease or Dementia as of 2010.

CONCLUSIONS

Truven Health used a variety of robust data sources to analyze the supply of behavioral health treatment across the broad lifespan of Rhode Island residents. We captured information on the independent practitioner workforce as well as capacity and program information for hospitals, mental health treatment facilities, and substance use disorder treatment facilities.

Key Findings for Children and Adolescents.

- Children and adolescents in Rhode Island face greater social and familial risks for the development of mental and substance use disorders than children in other New England states and the nation.
- Children and adolescents in Rhode Island experience relatively high rates of poverty. They are more likely to live with an unemployed parent, in a single-parent household, and in a less positive home environment.⁶⁰
- As noted by the 2014 Rhode Island Kids Count Fact Book, children most at risk of not achieving their full potential are children in poverty. Approximately one in five children in Rhode Island is poor.⁶¹

These risk factors lead to higher rates of mental health and substance abuse conditions.

- As they grow, children and adolescents in Rhode Island are more likely to develop attention deficit hyperactivity disorder and to use illicit drugs compared with the national average of children and adolescents across other states.

Our analyses of the supply of behavioral health services in Rhode Island suggests that although Rhode Island has an innovative vision and system for addressing the needs of children and adolescents, Rhode Island may see significant benefits from greater investment in primary and second preventive services for these individuals and their family supports.

Figure 25 describes interventions that can be effective at preventing the development of mental and substance use disorders as children develop into young adults. As recently noted by the National Research Council and Institute of Medicine:

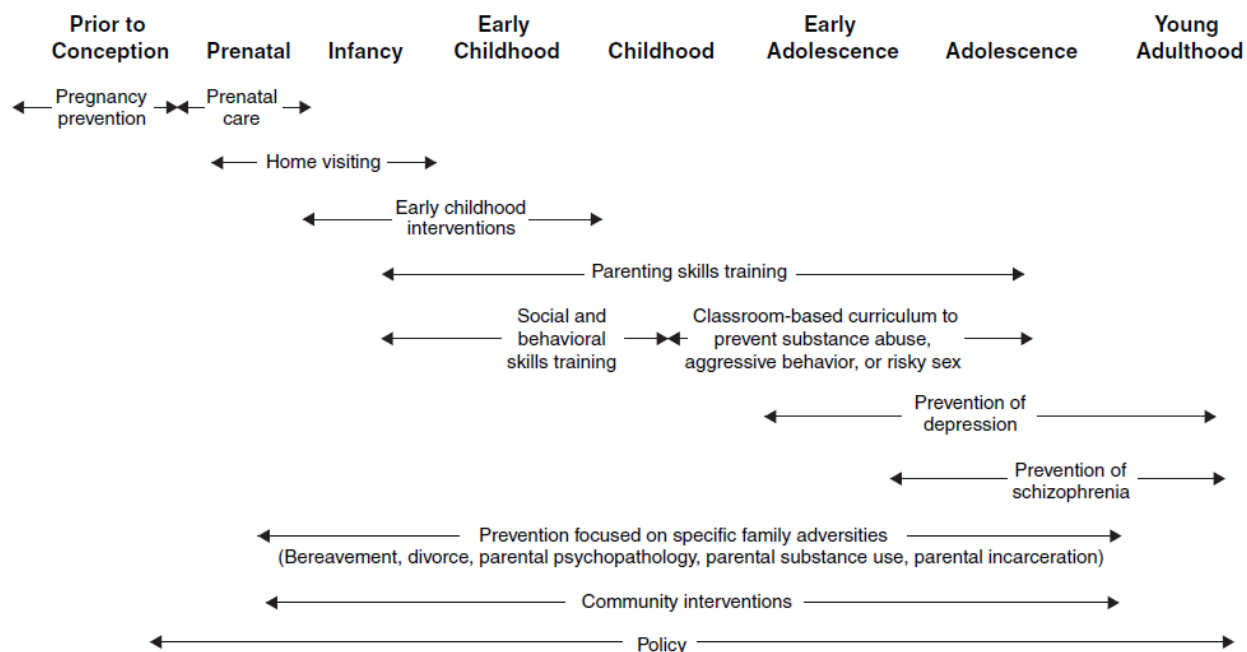
*Supporting the development of children requires that infrastructure be in place in more than one system—public health, health care, education, community agencies—to support and finance culturally appropriate preventive interventions at multiple levels.*⁶²

⁶⁰ Woodward R, Mark TL, Levit, K. Rhode Island Behavioral Healthcare Project: Demand Report. Submitted to Rhode Island April 20, 2015.

⁶¹ Rhode Island KIDS COUNT. 2014 Rhode Island Kids Count Factbook. Providence, RI: Author; 2014. <http://www.rikidscount.org/Portals/0/Uploads/Documents/2014Factbook-noart.pdf>

⁶² National Research Council and Institute of Medicine. 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. O’Connell ME, Boat T, Warner, KE, Eds. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press; 2009.

Figure 25. Interventions by Developmental Phase



Source: The National Academies. Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Report Brief for Policymakers. March, 2009.

Examples of effective preventive interventions include: Pregnancy prevention (e.g., screening for substance use); home visiting programs (e.g., Nurse Family Partnership and Healthy Families New York), early intervention services; parenting skills training (e.g., Incredible Years, Positive Parenting Program, Strengthening Families Program; For Parents and Youth; Adolescent Transitions Program); comprehensive early education programs (e.g., Perry Preschool Program, Carolina Abecedarian Program, Child-Parent Center); family disruption interventions (e.g., New Beginnings Program); and school based programs (e.g., Good Behavior Game, Life Skills Training, Linking Interests of Families and Teachers, Fast Track, Seattle Social Development Project, Adolescents Transitions Program).⁶³

⁶³ 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: The National Academies Press.

These programs have been shown to be effective in reducing the odds that a child will develop a mental health or substance use disorder. They have also been found to reduce child maltreatment; to reduce aggressive, disruptive, or antisocial behaviors among children; to improve parent-child interaction; to improve academic achievement, high school graduation rates, and college attendance; to increase employment and earnings, and to reduce arrest rates.⁶⁴

The types of programs that Rhode Island provides today that they may want to expand or enhance include the following:

- Evidence-based home visiting services (e.g., Healthy Families America, Nurse-Family Partnership, and Parents as Teachers; First Connections; Positive Parenting Program; Common Sense Parenting)
- Early intervention services
- Early childhood programs (e.g., Early Head Start)

Additionally, Rhode Island appears to have a shortage of Department of Children, Youth & Families case-workers and step-down community services for children and adolescents following a psychiatric hospitalization.

These services are provided across an array of settings, state agencies, and payers. Thus, coordination, performance monitoring, and accountability will be critical challenges in treatment-effective and cost-effective service implementation.

A key challenge for Rhode Island will be in moving the system from the delivery of reactive treatment services, to one focused on improving the health of its children through prevention and early intervention. As noted by the National Academy of Sciences:

Mental, emotional, and behavioral disorders incur high psychosocial and economic costs for the young people who experience them, for their families, and for the society in which they live, study, and will work. Yet there is a significant imbalance in the nation's efforts to address such disorders. People await their emergence and then attempt to treat them, to cure them if possible, or to limit the damage they cause if not. This happens with any number of expensive interventions, ranging from psychiatric care to incarceration. Myopically, we devote minimal attention to preventing future disorders or the environmental exposures that increase risk.

⁶⁴ Ibid.

Key Findings for Adults.

- Adults in Rhode Island had the highest rate of general hospital admissions for mental health issues among adults in New England states and nationally.
- Rates of drug and alcohol use in Rhode Island typically are higher than the national average.⁶⁵
- Rhode Island adults die more frequently from narcotics and hallucinogens than adults in other New England states.
- Adults in Rhode Island are more likely to report unmet need for treatment of mental and substance use disorders than residents in the other comparison states.

Behavioral health treatment services fall into three general categories: inpatient, outpatient, and medications or biomedical interventions. Inpatient care includes primarily short-term hospitalizations for psychiatric or substance use disorder life-threatening crises. Outpatient care primarily consists of outpatient visits in which therapies and medications may be provided. Outpatient providers may be professionals such as primary care physicians, psychiatrists, pediatricians, psychologists, social workers, counselors, and nurses that work in independent practices or facility organizations, such as community mental health clinics. An array of medications exists to treat mental and substance use disorders, in addition to some biomedical interventions such as electroconvulsive stimulation.

Although the outpatient, inpatient, and medications or biomedical interventions form the scaffolding for behavioral health treatment, this scaffolding is insufficient to provide high-quality, cost-effective treatment, particularly for individuals with severe mental illnesses.⁶⁶ Without the glue that ties these services together, patients may cycle into and out of hospitals, neglect to take their medications, develop physical illnesses such as diabetes and hepatitis, become homeless or imprisoned, and have a much higher risk of early death.

The results of our analysis of Rhode Island's behavioral health system indicate that the scaffolding in Rhode Island already exists. Rhode Island does not appear to be lacking in hospital beds, most types of professionals who offer behavioral health treatment, or specialty

⁶⁵ Woodward, R, Mark TL, Levit, K. Rhode Island Behavioral Healthcare Project: Demand Report. Submitted to Rhode Island April 20, 2015.

⁶⁶ Kaplan L. The Role of Recovery Support Services in Recovery-Oriented Systems of Care. DHHS Publication No. (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Services, Substance Abuse and Mental Health Services Administration; 2008. <http://store.samhsa.gov/product/The-Role-of-Recovery-Support-Services-in-Recovery-Oriented-Systems-of-Care/SMA08-4315>

mental health or substance abuse specialty facilities. However, the glue that allows this framework to produce high-quality, cost-effective results could be strengthened.

- Building up Rhode Island’s community-based behavioral health system is one way to strengthen and improve the state’s behavioral health treatment framework and reduce avoidable hospital admissions. Specific examples include:
 - After 2011, Rhode Island had no assertive community treatment programs. Additionally, Rhode Island lacks family psychoeducation. The state should consider working these evidence-based practices into its community treatment framework.
 - The rate of homelessness among those served by the Rhode Island mental health system was higher than the national average (5% versus 3.3%). Yet, only 2.6 percent of individuals with serious mental illness served by the Rhode Island mental health system received supportive housing.
- Another key consideration is improving transitions across systems of care, particularly from costly inpatient and institutionalized settings (e.g., jails), to community settings. For example:
 - Among Rhode Island Medicaid beneficiaries who were hospitalized for a mental illness, one in five had no follow-up mental health treatment in 30 days.
- Rhode Island may also want to examine the distribution of resources across the state. Although in general, Rhode Island appears to have an adequate supply of behavioral health specialists, for example, they may not be accessible by those most in need or exist in the correct specializations for particular needs. For example:
 - Of the five counties in Rhode Island, three are designated as having at least one community health center with a shortage of mental health professionals: Newport County (1), Providence County (6), and Washington County (1).
 - Rhode Island had a lower per capita number of substance abuse counselors and other behavioral health counselors than the national average. Rhode Island ranked lowest of all New England states for other behavioral health counselors and second lowest for substance abuse counselors, though other types of professionals (e.g., clinical social workers) provide counseling services in the state.

- Rhode Island had no mental health programs offering specialized services for traumatic brain injury. It had the lowest percent of mental health facilities offering programs specifically designed for Veterans or for individuals with Alzheimer’s disease or Dementia in 2010.
- Recent behavioral health treatment program closings in Rhode Island should be assessed and factored into the framework, including post-2012 closings for a significant number of community residential treatment beds.

APPENDIX A: DATA SOURCE SUMMARIES

Area Health Resources Files (AHRF)

This data file consists of data from more than 50 sources and is released annually. It is sponsored by the Health Resources and Services Administration. The data can be used to compare counties' available health resources and health status indicators. The website also provides demographic data and training information on over 50 health professions.

Data Access Link: <http://ahrf.hrsa.gov/download.htm>

Behavioral Health, U.S. 2012 (BHUS)

This publication is issued biannually by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services. It serves as a comprehensive resource for national behavioral health statistics by compiling information from different data sources, journal articles, online tools and other publications. National estimates are presented on numerous aspects of behavioral health and substance use, including prevalence of disorders, number of beds, providers and facilities in which treatment is offered, and spending on treatment.

Data Access Link: <http://www.samhsa.gov/data/sites/default/files/2012-BHUS.pdf>

Kaiser Family Foundation State Health Facts

This website contains data from multiple sources and is regularly updated. It has national- and state-level information on the following topics: demographics, health costs and budgets, health coverage and uninsured indicators, health insurance and managed care, health reform, health status, HIV/AIDS, Medicaid and Children's Health Insurance Program (CHIP), Medicare, minority health, providers and service use, and women's health.

Data Access Link: <http://kff.org/statedata>

Mental Health, U.S. 2010 (MHUS)

This publication was issued by SAMHSA. It provides information on the mental health status of the U.S. population, the providers and settings for mental health services, the types of mental health services and rates of utilization, and costs and sources of funding for mental health services.

Data Access Link: <http://archive.samhsa.gov/data/2k12/MHUS2010/MHUS-2010.pdf>



National Mental Health Services Survey (N-MHSS)

The N-MHSS is an annual survey of all known public and private mental health treatment facilities in the United States. It is sponsored by SAMHSA.

Data Access Link: <https://info.nmhss.org/>

National Survey of Substance Abuse Treatment Services (N-SSATS)

N-SSATS measures the scope and use of drug treatment services nationally and by state. It includes information on organizational focus, service orientation, services available, clients in treatment by type of care, and capacities of hospital inpatient and residential treatment facilities. It has evolved from survey efforts sponsored by the National Institute on Drug Abuse (NIDA) in the 1970s, and is sponsored by SAMHSA. N-SSATS is designed to collect data from each physical location where treatment services are provided. Accordingly, SAMHSA requests that state substance abuse agencies use the point of delivery of service (i.e., physical location) as the defining factor for a facility. Because of the different state administrative systems, however, there are some inconsistencies in implementation.

Data Access Link: <http://www.dasis.samhsa.gov/dasis2/nssats.htm>

US Census Bureau

The US Census Bureau collects data on mental disabilities, mental or emotional conditions, and developmental conditions. The Bureau collects data on disability primarily through the American Community Survey (ACS) and the Survey of Income and Program Participation (SIPP). The definitions of disability are not always the same, so caution should be taken when making comparisons across surveys. Generally, the SIPP estimates of disability prevalence are broader and encompass a greater number of activities on which disability status is assessed. The ACS has a more narrow definition but is capable of producing estimates for states, counties, and metropolitan areas. Because the ACS has replaced the decennial long form as the source for small area statistics, there are no disability data in the 2010 Census. In addition to these recent data sources, the Census Bureau has produced disability estimates from the 2000 Census and the Current Population Survey Annual Social and Economic Supplement (CPS ASEC).

Data Access Link: <http://www.census.gov/people/disability/>

APPENDIX B: RESULTS TABLES

All Ages

All Ages: Table 1 Primary Care and General Practice, Office-Based Physicians in New England and the United States, N per 100,000 Population, 2010–2012

Location	Patient Care, ^a N per 100,000 Population			Hospital Residents, N per 100,000 Population			Office-Based Physicians, N per 100,000 Population		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
Rhode Island	89.6	92.4	93.8	25.4	24.8	23.8	15.5	15.9	16.1
Connecticut	81.7	82.1	84.0	19.6	22.8	22.4	13.6	13.6	14.1
Maine	105.0	107.0	107.0	11.2	9.9	10.7	36.8	35.9	35.6
Massachusetts	101.2	102.1	102.7	21.0	21.7	22.7	17.1	17.4	18.0
New Hampshire	90.8	91.9	92.5	6.9	7.1	7.9	30.9	31.0	30.6
Vermont	107.4	108.1	108.5	14.2	14.5	13.1	43.5	42.9	43.8
National	73.0	73.8	74.5	11.4	12.0	12.2	24.3	24.4	24.6

Source: ARF. Derived from census population (total, all ages) estimates for 2010, 2011, and 2012.

Notes:

1. Primary Care includes General Family Medicine, General Practice, General Internal Medicine, and General Pediatrics. Subspecialties within these specialties are excluded.
2. Federal physicians and physicians age 75 and over are excluded.

^aPatient Care includes Office Based and Hospital Based (FT) Staff.

^bThe following subspecialties are included in General Practice: General Practice, General Family Medicine, and Family Medicine Subspecialties; Includes physicians in patient services such as those provided by pathologists.

All Ages: Table 2 Psychiatric Physicians, Number per 100,000 Population, in New England and the United States, 2010–2012

Location	Total Patient Care			Office-Based			Hospital Full-Time Staff ^a		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
Rhode Island	17.4	17.8	17.2	10.5	10.2	10.0	3.3	3.5	3.7
Connecticut	21.0	20.9	22.0	14.8	14.6	15.6	3.7	3.3	3.5
Maine	14.3	14.1	13.2	9.8	9.5	9.0	3.2	3.3	3.2
Massachusetts	27.2	27.2	26.8	18.4	18.4	18.1	4.5	4.3	4.3
New Hampshire	12.4	12.1	12.6	8.8	9.0	8.8	1.2	0.8	1.3
Vermont	20.6	20.4	21.1	15.7	15.6	16.1	3.0	2.4	2.6
National	11.1	11.0	11.0	8.2	8.2	8.2	1.5	1.3	1.3

Source: ARF. Derived from census population (total, all ages) estimates for 2010, 2011, and 2012.

Notes:

Federal physicians are excluded.

^a Hospital Full-Time Staff includes physicians employed under contract with hospitals to provide direct patient care, and excludes hospital residents.

**All Ages: Table 3 Percent of Psychiatrists out of
Total Physicians, New England
States and National, 2014**

Location	%
Rhode Island	11
Connecticut	15
Maine	14
Massachusetts	15
New Hampshire	12
Vermont	11
National	16

Source: KFF at <http://kff.org/other/state->

Notes:

Data includes currently active allopathic physicians (MDs)

All Ages: Table 4 Other Professionals per 100,000 Total Population, by Discipline, in New England and the United States, Select Years

Location	Psycho- logists	Psychiatric nurses	Clinical Social Workers	Substance abuse counselors	Counselors	Marriage and family therapists
	2011	2008 ²	2011 ¹	2011 ¹	2011 ^{1,3}	2011 ¹
Rhode Island	54.6	12.4	163.9	7.6	28.2	40.3
Connecticut	46.1	9.8	134.0	25.9	50.3	27.1
Maine	30.5	19.3	186.7	53.9	78.9	6.1
Massachusetts	75.8	7.7	172.6	2.6	87.5	9.4
New Hampshire	42.0	17.3	42.6	21.7	61.0	7.9
Vermont	56.8	2.1	149.3	11.2	66.6	26.2
National	30.7	4.5	62.0	15.4	46.4	20.0

Source: Substance Abuse and Mental Health Services Administration. (2013). Behavioral Health, United States, 2012. HHS Publication No. (SMA)13-4797. Rockville, MD: Substance Abuse and Mental Health Services Administration. Tables 93, 94, and 95

Notes:

¹Estimates obtained from Mental Health Mailing Lists and Marketing Solutions (Psychlist Marketing, Inc., 2007). Based on State licensure data with duplicate addresses removed.

²Estimates obtained from 2008 National Sample Survey of Registered Nurses (U.S. Department of Health and Human Services, 2010).

³Counselors include mental health and substance abuse counselors.

All Ages: Table 5 Hospitals, Hospital Beds, and Short-Term Inpatient Hospitals With Alcohol/Drug Abuse Inpatient or Psychiatric Care in New England and the United States, 2010–2012

Location	Hospitals, N per 100,000 Population ¹	Hospital Beds, N per 1,000 Population			Short-Term Inpatient Hospital					
					With Alcohol/Drug Abuse Inpatient Care, N per 1,000,000			With Psychiatric Care N per 1,000,000		
					2009	2010	2011	2009	2010	2011
Rhode Island	1.0	2.4	2.3	2.3	0.9	0.9	1.0	2.8	5.7	5.7
Connecticut	0.9	2.3	2.2	2.3	0.8	1.4	1.4	5.3	5.9	5.9
Maine	2.8	2.7	2.7	2.7	4.5	3.8	5.3	6.8	6.8	8.3
Massachusetts	1.2	2.4	2.4	2.4	0.6	0.5	0.8	5.1	5.8	6.1
New Hampshire	2.1	2.2	2.2	2.1	0.0	0.0	0.0	6.8	6.1	6.1
Vermont	2.2	2.1	1.9	2.0	1.6	1.6	1.6	6.4	3.2	6.4
National	1.6	2.6	2.6	2.6	1.3	1.1	1.1	4.3	4.1	4.1

Source: Kaiser Family Foundation. Total Hospitals. State Health Facts. <http://kff.org/other/state-indicator/total-hospitals/> and Area Resource File (ARF)

Notes:

1. Data include staffed beds for community hospitals, which represent 85% of all hospitals. Federal hospitals, long-term care hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical
2. Figures may not sum to totals due to rounding.
3. The number of short term general hospitals or hospital subsidiaries which report that they provide certain inpatient and outpatient services was extracted from the AHA Annual Survey of Hospitals (Copyright).

¹N per 100,000 population was derived using census data for all ages for the respective years 2010, 2011, and 2012.

All Ages: Table 6

**Inpatient Psychiatric
Beds for Adults in
Rhode Island, 2015**

Hospital	Beds (N)
Eleanor Slater Hospital	
Long-term beds	150
Butler Hospital	132
Kent Hospital	
Inpatient voluntary beds	12
Psychiatric unit at Butler	29
Landmark Hospital	18
Newport Hospital	15
Veterans Hospital	21
Rhode Island Hospital	56
CharterCare	
Roger Williams Medical Center ^a	39
St. Joseph Hospital	63
TOTAL	535

Source: Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH), via personal communication, June 2nd, 2015.

Notes:

^aIncludes 15-bed inpatient locked/voluntary medical dextoxification unit. Roger Williams is the only hospital in Rhode Island with inpatient substance use disorder services at ASAM level 4.

All Ages: Table 7

**Substance Abuse Treatment Facilities and Clients,
New England and National, 2010-2012**

Location	2010		2011		2012	
	Facilities	All Clients	Facilities	All Clients	Facilities	All Clients
	N					
Rhode Island						
TOTAL	53	7,362	59	9,742	63	8,499
TOTAL per 100,000 Population ¹	5	699	6	928	6	809
Connecticut						
TOTAL	195	28,250	188	25,914	223	37,022
TOTAL per 100,000 Population ¹	5	789	5	722	6	1,031
Maine						
TOTAL	179	10,593	213	10,769	223	13,172
TOTAL per 100,000 Population ¹	13	798	16	811	17	991
Massachusetts						
TOTAL	307	39,444	322	46,891	328	45,757
TOTAL per 100,000 Population ¹	5	601	5	710	5	689
New Hampshire						
TOTAL	52	5,237	54	5,931	59	5,946
TOTAL per 100,000 Population ¹	4	398	4	450	4	450
Vermont						
TOTAL	42	4,489	42	4,182	43	4,023
TOTAL per 100,000 Population ¹	7	717	7	668	7	643
National						
TOTAL	13,339	1,175,462	13,720	1,224,127	14,311	1,248,905
TOTAL per 100,000 Population ¹	4	380	4	393	5	398

Source: National Survey on Substance Abuse Treatment Services (N-SSATS), which is an annual census of all substance abuse treatment facilities in the United States, both public and private.

Notes:

1. N-SSATS attempts to obtain responses from all known treatment facilities, but it is a voluntary
2. Clients in treatment were measured as of March 31 of each year.

^a Derived from census population (total, all ages) estimates for 2010, 2011, and 2012.

All Ages: Table 8 Substance Abuse Treatment by Type of Care in New England and the United States, 2010–2012

Location/Type of Facility	2010				2011				2012			
	Facilities ^a		All Clients		Facilities ^a		All Clients		Facilities ^a		All Clients	
	N	%	N	%	N	%	N	%	N	%	N	%
Rhode Island												
Outpatient	46	86.8	6,976	94.8	51	86.4	960	95.4	56	88.9	8,148	95.9
Regular	40	75.5	4,068	55.3	46	78.0	N/A	N/A	52	82.5	4,934	58.1
Intensive	21	39.6	193	2.6	22	37.3	N/A	N/A	31	49.2	523	6.2
Day treatment/partial hosp.	10	18.9	62	0.8	6	10.2	N/A	N/A	9	14.3	107	1.3
Detoxification	11	20.8	139	1.8	11	18.6	N/A	N/A	16	25.4	106	1.2
Methadone/buprenorphine	12	22.6	2,514	36.1	14	23.7	N/A	N/A	15	23.8	2,478	29.2
Residential (nonhospital)	14	26.4	325	4.4	14	23.7	46	4.6	16	25.4	319	3.8
Short term	2	3.8	7	0.1	6	10.2	N/A	N/A	8	12.7	82	1.0
Long term	14	26.4	318	4.3	13	22.0	N/A	N/A	15	23.8	233	2.7
Detoxification	2	3.8	-	0.0	-	0.0	N/A	N/A	2	3.2	4	0.0
Hospital Inpatient	4	7.5	61	0.8	5	8.5	N/A	N/A	4	6.3	32	0.4
Treatment	3	5.7	23	0.3	3	5.1	N/A	N/A	4	6.3	4	0.0
Detoxification	4	7.5	38	0.5	5	8.5	N/A	N/A	3	4.8	28	0.3
TOTAL	53	N/A	7,362	N/A	59	N/A	1,006	N/A	63	N/A	8,499	N/A
Connecticut												
Outpatient	139	71.3	26,654	94.4	134	71.3	596	97.4	166	74.4	35,160	95.0
Regular	120	61.5	10,720	37.9	119	63.3	N/A	N/A	143	64.1	15,863	42.8
Intensive	76	39.0	1,584	5.6	77	41.0	N/A	N/A	91	40.8	4,342	11.7
Day treatment/partial hosp.	30	15.4	343	1.2	32	17.0	N/A	N/A	32	14.3	314	0.8
Detoxification	30	15.4	376	1.3	27	14.4	N/A	N/A	32	14.3	608	1.6
Methadone/buprenorphine	31	15.9	13,631	48.3	30	16.0	N/A	N/A	36	16.1	14,033	37.9
Residential (nonhospital)	52	26.7	1,278	4.5	54	28.7	16	2.6	65	29.1	1,596	4.3
Short term	17	8.7	323	1.1	18	9.6	N/A	N/A	26	11.7	475	1.3
Long term	39	20.0	921	3.3	42	22.3	N/A	N/A	47	21.1	1,050	2.8
Detoxification	3	1.5	34	0.1	2	1.1	N/A	N/A	5	2.2	71	0.2
Hospital Inpatient	17	8.7	318	1.1	16	8.5	N/A	N/A	14	6.3	266	0.7
Treatment	12	6.2	118	0.4	12	6.4	N/A	N/A	12	5.4	136	0.4
Detoxification	16	8.2	200	0.7	15	8.0	N/A	N/A	13	5.8	130	0.4
TOTAL	195	N/A	28,250	N/A	188	N/A	612	N/A	223	N/A	37,022	N/A
Maine												
Outpatient	155	86.6	10,194	96.2	187	87.8	590	83.9	195	87.4	12,613	95.8
Regular	148	82.7	5,811	54.9	180	84.5	N/A	N/A	188	84.3	8,087	61.4
Intensive	38	21.2	666	6.3	43	20.2	N/A	N/A	47	21.1	671	5.1
Day treatment/partial hosp.	8	4.5	35	0.3	14	6.6	N/A	N/A	12	5.4	115	0.9
Detoxification	16	8.9	29	0.3	16	7.5	N/A	N/A	16	7.2	50	0.4
Methadone/buprenorphine	11	6.1	3,653	34.5	10	4.7	N/A	N/A	14	6.3	3,690	28.0
Residential (nonhospital)	24	13.4	331	3.1	28	13.1	113	16.1	26	11.7	294	2.2
Short term	7	3.9	64	0.6	8	3.8	N/A	N/A	9	4.0	89	0.7
Long term	21	11.7	253	2.4	24	11.3	N/A	N/A	22	9.9	205	1.6
Detoxification	1	0.6	14	0.1	2	0.9	N/A	N/A	-	0.0	-	0.0
Hospital Inpatient	5	2.8	68	0.6	7	3.3	N/A	N/A	10	4.5	265	2.0
Treatment	4	2.2	26	0.2	4	1.9	N/A	N/A	7	3.1	101	0.8
Detoxification	5	2.8	42	0.4	6	2.8	N/A	N/A	8	3.6	164	1.2
TOTAL	179	N/A	10,593	N/A	213	N/A	703	N/A	223	N/A	13,172	N/A

All Ages: Table 8 Cont'd. Substance Abuse Treatment by Type of Care in New England and the United States, 2010–2012

Location/Type of Facility	2010				2011				2012			
	Facilities ^a		All Clients		Facilities ^a		All Clients		Facilities ^a		All Clients	
	N	%	N	%	N	%	N	%	N	%	N	%
Massachusetts												
Outpatient	192	62.5	35,007	88.8	205	63.7	1,199	91.4	202	61.6	41,921	91.6
Regular	172	56.0	20,335	51.6	184	57.1	N/A	N/A	181	55.2	24,382	53.3
Intensive	75	24.4	2,196	5.6	72	22.4	N/A	N/A	60	18.3	1,478	3.2
Day treatment/partial hosp.	46	15.0	501	1.3	33	10.2	N/A	N/A	33	10.1	566	1.2
Detoxification	46	15.0	2,131	5.4	60	18.6	N/A	N/A	38	11.6	699	1.5
Methadone/buprenorphine	32	10.4	9,844	25.0	46	14.3	N/A	N/A	51	15.5	14,796	32.3
Residential (nonhospital)	115	37.5	3,337	8.5	115	35.7	66	5.0	127	38.7	3,151	6.9
Short term	36	11.7	735	1.9	33	10.2	N/A	N/A	40	12.2	855	1.9
Long term	90	29.3	2,356	6.0	97	30.1	N/A	N/A	102	31.1	2,037	4.5
Detoxification	11	3.6	246	0.6	7	2.2	N/A	N/A	12	3.7	259	0.6
Hospital Inpatient	33	10.7	1,100	2.8	31	9.6	47	3.6	30	9.1	685	1.5
Treatment	26	8.5	573	1.5	25	7.8	N/A	N/A	18	5.5	240	0.5
Detoxification	31	10.1	527	1.3	30	9.3	N/A	N/A	26	7.9	445	1.0
TOTAL	301	N/A	39,444	N/A	322	N/A	1,312	N/A	328	N/A	45,757	N/A
New Hampshire												
Outpatient	39	75.0	4,909	93.7	40	74.1	430	97.5	46	78.0	5,554	93.4
Regular	34	65.4	2,725	52.0	35	64.8	N/A	N/A	40	67.8	2,719	45.7
Intensive	11	21.2	198	3.8	13	24.1	N/A	N/A	19	32.2	374	6.3
Day treatment/partial hosp.	2	3.8	47	0.9	1	1.9	N/A	N/A	5	8.5	7	0.1
Detoxification	11	21.2	107	2.0	12	22.2	N/A	N/A	14	23.7	433	7.3
Methadone/buprenorphine	9	17.3	1,832	35.0	10	18.5	N/A	N/A	10	16.9	2,021	34.0
Residential (nonhospital)	17	32.7	323	6.2	19	35.2	11	2.5	21	35.6	384	6.5
Short term	9	17.3	93	1.8	9	16.7	-	0.0	15	25.4	146	2.5
Long term	12	23.1	168	3.2	14	25.9	N/A	N/A	16	27.1	195	3.3
Detoxification	8	15.4	62	1.2	7	13.0	N/A	N/A	9	15.3	43	0.7
Hospital Inpatient	2	3.8	5	0.1	2	3.7	-	0.0	2	3.4	8	0.1
Treatment	-	0.0	-	0.0	-	0.0	N/A	N/A	-	0.0	-	0.0
Detoxification	2	3.8	5	0.1	2	3.7	N/A	N/A	2	3.4	8	0.1
TOTAL	52	N/A	5,237	N/A	54	N/A	441	N/A	59	N/A	5,946	N/A
Vermont												
Outpatient	35	83.3	4,195	93.5	35	83.3	316	95.8	37	86.0	3,751	93.2
Regular	35	83.3	3,201	71.3	36	85.7	N/A	N/A	37	86.0	2,556	63.5
Intensive	15	35.7	348	7.8	16	38.1	N/A	N/A	16	37.2	357	8.9
Day treatment/partial hosp.	5	11.9	95	2.1	4	9.5	N/A	N/A	4	9.3	122	3.0
Detoxification	6	14.3	15	0.3	5	11.9	N/A	N/A	6	14.0	20	0.5
Methadone/buprenorphine	7	16.7	536	11.9	9	21.4	N/A	N/A	9	20.9	696	17.3
Residential (nonhospital)	6	14.3	121	2.7	6	14.3	2	0.6	8	18.6	137	3.4
Short term	2	4.8	47	1.0	2	4.8	N/A	N/A	3	7.0	50	1.2
Long term	3	7.1	62	1.4	3	7.1	N/A	N/A	4	9.3	79	2.0
Detoxification	3	7.1	12	0.3	3	7.1	N/A	N/A	3	7.0	8	0.2
Hospital Inpatient	5	11.9	173	3.9	6	14.3	12	3.6	6	14.0	135	3.4
Treatment	4	9.5	125	2.8	4	9.5	N/A	N/A	3	7.0	96	2.4
Detoxification	5	11.9	48	1.1	6	14.3	N/A	N/A	6	14.0	39	1.0
TOTAL	42	N/A	4,489	N/A	42	N/A	330	N/A	43	N/A	4,023	N/A

All Ages: Table 8 Cont'd. Substance Abuse Treatment by Type of Care in New England and the United States, 2010–2012

Location/Type of Facility	2010				2011				2012			
	Facilities ^a		All Clients		Facilities ^a		All Clients		Facilities ^a		All Clients	
	N	%	N	%	N	%	N	%	N	%	N	%
National												
Outpatient	10,753	80.6	1,056,532	89.9	11,101	80.9	71,687	86.9	11,650	81.4	1,120,615	89.7
Regular	9,914	74.3	593,077	50.5	10,295	75.0	N/A	N/A	10,858	75.9	629,794	50.4
Intensive	5,990	44.9	138,188	11.8	6,089	44.4	N/A	N/A	6,427	44.9	148,893	11.9
Day treatment/partial hosp.	1,678	12.6	22,458	1.9	1,702	12.4	N/A	N/A	1,762	12.3	26,530	2.1
Detoxification	1,227	9.2	13,216	1.1	1,294	9.4	N/A	N/A	1,367	9.6	15,847	1.3
Methadone/buprenorphine	1,137	8.5	289,593	24.6	1,223	8.9	N/A	N/A	1,316	9.2	301,551	24.1
Residential (nonhospital)	3,452	25.9	103,692	8.8	3,524	25.7	9,738	11.8	3,566	24.9	110,843	8.9
Short term	1,691	12.7	26,014	2.2	1,779	13.0	N/A	N/A	1,804	12.6	29,391	2.4
Long term	2,801	21.0	70,129	6.0	2,881	21.0	N/A	N/A	2,932	20.5	70,734	5.7
Detoxification	893	6.7	7,549	0.6	890	6.5	N/A	N/A	894	6.2	10,718	0.9
Hospital Inpatient	748	5.6	15,238	1.3	740	5.4	1,107	1.3	780	5.5	17,447	1.4
Treatment	548	4.1	8,762	0.7	548	4.0	N/A	N/A	578	4.0	10,497	0.8
Detoxification	666	5.0	6,476	0.6	658	4.8	N/A	N/A	686	4.8	6,950	0.6
TOTAL	13,339	N/A	1,175,462	N/A	13,720	N/A	82,532	N/A	14,311	N/A	1,248,905	N/A

Source: The National Survey on Substance Abuse Treatment Services (N-SSATS), which is an annual census of all substance abuse treatment facilities in the United States, both public and private

Notes:

1. N-SSATS attempts to obtain responses from all known treatment facilities, but it is a voluntary survey. There is no adjustment for the approximately 4% facility nonresponse.
2. Clients in treatment were measured as of March 31 of each year.

^a Facilities may provide more than one type of care.

All Ages: Table 9

Opioid Treatment Programs (OTPs) in New England and the United States, 2010–2012

Location/Program	2010		2011		2012	
	N	%	N	%	N	%
Rhode Island						
Facilities with OTPs ¹	13	1.1	15	1.3	13	1.1
Clients in Facilities with OTPs						
Methadone	2,547	99.5	3,105	98.4	2,358	96.3
Buprenorphine	13	0.5	51	1.6	91	3.7
Total	2,560	100	3,156	100	2,449	100
Connecticut						
Facilities with OTPs ^a	41	100	33	100	39	100
Clients in Facilities with OTPs						
Methadone	13,943	97.5	11,849	96.6	13,856	98.7
Buprenorphine	355	2.5	421	3.4	186	1.3
Total	14,298	100	12,270	100	14,042	100
Maine						
Facilities with OTPs ^a	11	0.9	9	0.8	10	0.9
Clients in Facilities with OTPs						
Methadone	3,624	92.5	3,529	98	3,696	96
Buprenorphine	292	7.5	72	2	169	4
Total	3,916	100	3,601	100	3,865	100
Massachusetts						
Facilities with OTPs ^a	49	4.2	59	5.0	51	4.4
Clients in Facilities with OTPs						
Methadone	10,329	97.2	15,171	97.6	15,341	96.9
Buprenorphine	299	2.8	378	2.4	491	3.1
Total	10,628	100	15,549	100	15,832	100
New Hampshire						
Facilities with OTPs ^a	8	0.7	8	0.7	8	100
Clients in Facilities with OTPs						
Methadone	1,926	99.8	1,984	99.9	2,224	99.8
Buprenorphine	3	0.2	1	0.1	5	0.2
Total	1,929	100	1,985	100	2,229	100

All Ages: Table 9 Cont'd. Opioid Treatment Programs (OTPs) in New England and the United States, 2010–2012

Location/Program	2010		2011		2012	
	N	%	N	%	N	%
Vermont						
Facilities with OTPs ^a	13	1.1	8	0.7	8	0.7
Clients in Facilities with OTPs						
Methadone	2,547	99.5	553	74.1	714	60.5
Buprenorphine	13	0.5	193	25.9	184	20
Total	2,560	100	746	100	898	100
National						
Facilities with OTPs ^a	1,166	100	1,189	100	1,167	100
Clients in Facilities with OTPs						
Methadone	298,170	97.9	306,440	97.8	306,512	98
Buprenorphine	6,486	2.1	7,020	2.2	7,409	2
Total	304,656	100	313,460	100	313,921	100

Source: National Survey on Substance Abuse Treatment Services (N-SSATS), which is an annual census of all substance abuse treatment facilities in the United States, both public and private

Notes:

1. N-SSATS attempts to obtain responses from all known treatment facilities, but it is a voluntary survey. There is no adjustment for the approximately 4% facility nonresponse.
2. Clients in treatment were measured as of March 31 of each year.

^a Percentage of all OTP facilities that are in the state or jurisdiction

All Ages: Table 10 Substance Abuse Treatment Facilities Receiving Federal, State, County, or Local Government Funds in New England and the United States, 2010–2012

Location	2010		2011		2012	
	N	%	N	%	N	%
Rhode Island	36	67.9	40	67.8	41	65.1
Connecticut	139	71.3	128	68.1	157	70.4
Maine	64	35.8	78	36.6	75	33.6
Massachusetts	187	60.9	203	63	225	68.6
New Hampshire	33	63.5	34	63	35	59.3
Vermont	36	67.9	31	73.8	33	76.7
National	7,977	59.8	8,121	59.2	8,286	57.9

Source: The National Survey on Substance Abuse Treatment Services (N-SSATS), which is an annual census of all substance abuse treatment facilities in the United States, both public and private.

Notes:

1. N-SSATS attempts to obtain responses from all known treatment facilities, but it is a voluntary survey. There is no adjustment for the approximately 4% facility
2. Facilities may be licensed by more than one agency/organization.

All Ages: Table 11

Substance Abuse Treatment Facilities by Programs for Special Groups in New England and the United States, 2010–2012

Location/Variable	2010		2011		2012	
	N	%	N	%	N	%
Rhode Island						
Co-occurring disorders	22	41.5	22	37.3	28	44.4
Criminal justice clients	13	24.5	10	16.9	13	20.6
Pregnant or postpartum women	5	9.4	9	15.3	10	15.9
Seniors or older adults	1	1.9	1	1.7	2	3.2
Connecticut						
Co-occurring disorders	111	56.9	106	56.4	130	58.3
Criminal justice clients	32	16.4	37	19.7	47	21.1
Pregnant or postpartum women	30	15.4	36	19.1	35	15.7
Seniors or older adults	14	7.2	28	14.9	35	15.7
Maine						
Co-occurring disorders	60	33.5	67	31.5	53	23.8
Criminal justice clients	36	20.1	31	14.6	30	13.5
Pregnant or postpartum women	12	6.7	17	8.0	17	7.6
Seniors or older adults	7	3.9	5	2.3	10	4.5
Massachusetts						
Co-occurring disorders	113	36.8	128	39.8	136	41.5
Criminal justice clients	43	14	46	14.3	40	12.2
Pregnant or postpartum women	39	12.7	47	14.6	56	17.1
Seniors or older adults	16	5.2	16	5.0	22	6.7
New Hampshire						
Co-occurring disorders	17	32.7	15	27.8	19	32.2
Criminal justice clients	8	15.4	6	11.1	7	11.9
Pregnant or postpartum women	12	23.1	8	14.8	12	20.3
Seniors or older adults	5	9.6	2	3.7	3	5.1
Vermont						
Co-occurring disorders	21	50	19	45.2	19	44.2
Criminal justice clients	7	16.7	9	21.4	12	20.9
Pregnant or postpartum women	7	16.7	8	19.0	14	32.6
Seniors or older adults	2	4.8	2	4.8	1	2.3
National						
Co-occurring disorders	4,975	37.3	4,943	36.0	5,288	37.0
Criminal justice clients	3,557	26.7	3,316	24.2	3,352	23.4
Pregnant or postpartum women	1,754	13.1	1,739	12.7	1,784	12.5
Seniors or older adults	916	6.9	875	6.4	952	6.7

Source: The National Survey on Substance Abuse Treatment Services (N-SSATS), which is an annual census of all substance abuse treatment facilities in the United States, both public and private.

All Ages: Table 12

Substance Abuse Treatment Facility Capacity and Utilization Rate in New England and the United States, 2010–2012

Location/Variable	2010		2011		2012	
	Residential	Hospital Inpatient	Residential	Hospital Inpatient	Residential	Hospital Inpatient
Rhode Island						
Facilities. N	14	3	14	3	16	2
Clients, ^a N	325	45	318	46	319	26
Designated beds, N	352	56	327	56	339	33
Utilization rate, ^b %	92.3	80.4	97.2	82.1	94.1	78.8
Designated beds/facility, mean	25	19	23	19	21	17
Connecticut						
Facilities. N	51	8	47	9	59	7
Clients, ^a N	1,268	216	1,295	235	1,477	212
Designated beds, N	1,284	259	1,414	259	1,604	232
Utilization rate, ^b %	98.8	83.4	91.6	90.7	92.1	91.4
Designated beds/facility, mean	25	32	30	29	27	33
Maine						
Facilities. N	20	3	20	3	18	5
Clients, ^a N	308	40	377	37	243	62
Designated beds, N	321	58	310	60	268	94
Utilization rate, ^b %	96	69	121.6	61.7	90.7	66
Designated beds/facility, mean	16	19	16	20	15	19
Massachusetts						
Facilities. N	115	23	112	21	118	19
Clients, ^a N	3,286	1,023	3,861	810	3,037	626
Designated beds, N	3,075	757	3,142	705	3,195	596
Utilization rate, ^b %	108.1	135.1	122.9	114.9	95.1	105
Designated beds/facility, mean	27	33	28	34	27	31
New Hampshire						
Facilities. N	14	0	17	1	17	1
Clients, ^a N	292	0	556	6	358	7
Designated beds, N	286	0	314	15	393	15
Utilization rate, ^b %	102.1	0	177.1	40	91.1	46.7
Designated beds/facility, mean	20	0	18	15	23	15

All Ages: Table 12 Cont'd.

Substance Abuse Treatment Facility Capacity and Utilization Rate in New England and the United States, 2010–2012

Location/Variable	2010		2011		2012	
	Residential	Hospital Inpatient	Residential	Hospital Inpatient	Residential	Hospital Inpatient
Vermont						
Facilities, N	6	3	5	4	7	4
Clients, ^a N	121	167	130	112	137	133
Designated beds, N	139	116	148	130	180	132
Utilization rate, ^b %	87.1	144	87.8	86.2	76.1	100.8
Designated beds/facility, mean	23	39	30	33	26	33
National						
Facilities, N	3046	490	3058	476	3083	475
Clients, ^a N	93,291	11,518	101,252	11,161	97,082	11,983
Designated beds, N	102,827	12,494	104,798	11,637	101,515	10,787
Utilization rate, ^b %	90.8	92.2	96.6	95.9	95.6	111.1
Designated beds/facility, mean	34	25	34	24	33	23

Source: The National Survey on Substance Abuse Treatment Services (N-SSATS), which is an annual census of all substance abuse treatment facilities in the United States, both public and private.

Notes:

1. N-SSATS attempts to obtain responses from all known treatment facilities, but it is a voluntary survey. There is no adjustment for the approximately 4% facility nonresponse.
2. Excludes facilities not reporting both client counts and number of beds, facilities whose client counts were reported by another facility, facilities that included client counts from other facilities, and facilities that did not respond to this question.

^a Clients in treatment measured as of March 31 of each year.

^b Because substance abuse treatment clients may also occupy nondesignated beds, utilization rates may be more than 100%.

All Ages: Table 13

**Detoxification Services and BHDDH-
Licensed Residential Beds for
Addiction and Co-occurring Mental
Health Issues in Rhode Island, 2015**

Detoxification Services	
BHDDH-licensed detoxification service delivery locations^a	Locations, n
Outpatient	6
Medical	3
Other detoxification facilities^b	Beds, n
Phoenix House of New England	36
ADCARE of Rhode Island	46
Roger Williams Hospital	15*
Licensed residential services	
BHDDH-licensed residential beds for SUD and co-occurring mental health issues at Symmetry^c	Beds, n
Adult male	175
Adult female	90
Adult co-ed	12
Adolescent male	21
Adolescent female	18
TOTAL	316

Source: Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH), Linda Mahoney, personal communication, February 10, 2015.

*Source: Roger Williams Medical Center website. Accessed 4/11/15 at <http://www.rwmc.org/services/substance-addiction/>.

Notes:

1. In December 2014, Rhode Island lost 16 adolescent male beds at Corkery House because of funding.
2. BHDDH does not license any hospital beds for substance use disorder detoxification, and therefore Linda Mahoney was unable to provide capacity information for specific hospitals. This includes Roger Williams Hospital, which is the only hospital in Rhode Island with a Level IV Alcohol & Drug Detoxification Program. Roger Williams has 24 beds for inpatient psychiatric care, and the number specific to detoxification was found on the center's website, as cited above.
3. All six methadone clinics in Rhode Island have BHDDH-licensed service capabilities for outpatient detox. Need changes monthly, so there are no capacity "slots," but supply is always available. BHDDH does not license the suboxone treatment agencies.

^aNot licensed by capacity/beds, only by licensed service delivery locations.

^bNot licensed by BHDDH.

^cSymmetry is new in the past 2 years.

All Ages: Table 14 Mental Health Facilities, by Facility Type, in New England and the United States, 2010

Location	Total Facilities, N	Distribution by Facility Type, %					Mental Health Facilities Providing 24-Hour Hospital Inpatient Care	Mental Health Facilities Providing <24-Hour Outpatient or Day Treatment or Partial Hospitalization Care
		Public Psychiatric Hospitals	Private Psychiatric Hospitals	General Hospitals	Outpatient Clinics	Multisetting Facilities	Facilities per 100,000 Population, N ^a	Facilities per 100,000 Population, N ^a
Rhode Island	67	1.5	3.0	7.5	44.8	1.5	11.94	3.6
Connecticut	202	1.5	1.0	12.9	60.9	8.4	15.84	4.6
Maine	123	1.6	1.6	6.5	43.1	4.1	10.57	5.9
Massachusetts	318	1.9	3.5	11.3	50.6	3.5	17.92	3.3
New Hampshire	73	1.4	1.4	12.3	45.2	5.5	17.81	3.9
Vermont	75	1.3	2.7	2.7	48.0	1.3	8.00	7.4
National	10,374	2.6	3.6	11.3	60.8	3.3	19.04	2.6

Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2010 National Mental Health Services Survey (N-MHSS)

Notes:

1. General Hospitals category includes only nonfederal general hospitals with separate psychiatric units.
2. Outpatient clinics category includes outpatient or day treatment or partial hospitalization facilities.
3. Facility Types may not sum to total, as age-specific facility types were removed from the original N-MHSS table to be redisplayed

^aDerived using 2010 Census data for total population (all ages).

All Ages: Table 15 Psych Beds in 24-Hour Hospital Inpatient Care and Residential Settings in New England and the United States, 2010

Location	Facilities, N	Beds (Inpatient and Residential) per 100,000 population, N	Inpatient beds per 100,000 population, N	Residential Beds per 100,000 Population, N
Rhode Island	67	94.0	47.3	46.7
Connecticut	202	70.2	43.3	26.9
Maine	123	84.7	42.5	42.2
Massachusetts	318	81.4	36.4	45.0
New Hampshire	73	85.9	43.4	42.5
Vermont	75	156.9	55.0	102.0
National	10,374	58.7	36.7	22.0

Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2010 National Mental Health Services Survey (N-MHSS)

Notes:

1. Data were as of 4/30/2010.
2. Rate per population derived using data obtained at Census.gov, based on total population estimates from July 1, 2010.
3. More recent survey data, when it becomes available, should be assessed as Rhode Island has had shifts in treatment design since 2010.

All Ages: Table 16 Percent of Total Mental Health Facilities Offering Select Treatment Approaches in New England and the United States, 2010

Location	Mental Health Treatment Approaches							
	Facilities responding, N ^a	Activity Therapy	Behavior Modification	Cognitive/Behavioral Therapy	Individual Psychotherapy	Integrated Dual Disorders Treatment	Psychotropic Medication Therapy	Telemedicine Therapy
Rhode Island	67	59.7	44.8	71.6	64.2	62.7	85.1	1.5
Connecticut	182	52.2	64.8	87.9	84.6	58.8	92.3	2.2
Maine	110	50.0	60.9	82.7	74.5	62.7	72.7	11.8
Massachusetts	267	57.3	59.9	89.1	85.8	55.1	85.0	2.2
New Hampshire	62	56.5	72.6	83.9	88.7	40.3	80.6	14.5
Vermont	65	50.8	76.9	73.8	70.8	69.2	78.5	4.6
National	9,139	51.2	65.1	88.2	85.8	54.3	83.2	15.4

Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration,

Notes:

1. Of the 9,139 facilities that were given the standard questionnaire, the mental health treatment approaches offered were unknown for two facilities.

^aOf the 10,374 facilities in the N-MHSS, basic facility information, service characteristics, and client counts were reported for 9,139 facilities. The remaining 1,235 facilities are excluded from this table because their service characteristics were not reported.

2. More recent survey data, when it becomes available, should be assessed as Rhode Island has had shifts in treatment design since 2010.

All Ages: Table 17 Percent of Total Mental Health Facilities Offering Supportive Services and Practices in New England and the United States, 2010

Location	Facilities responding, N ^a	Supportive Services and Practices						
		Assertive Community Treatment	Case Management	Legal Advocacy	Psycho-social Rehabilitation Services	Supported Employment	Supported Housing	Therapeutic Foster Care
Rhode Island	67	31.3	89.6	34.3	50.7	26.9	32.8	3.0
Connecticut	182	12.6	65.9	9.3	31.9	22.0	15.9	4.4
Maine	110	22.7	67.3	5.5	61.8	9.1	15.5	4.5
Massachusetts	267	16.5	59.2	11.6	41.6	12.0	10.1	3.4
New Hampshire	62	22.6	75.8	8.1	41.9	32.3	29.0	6.5
Vermont	65	26.2	73.8	10.8	56.9	35.4	35.4	10.8
National	9,139	17.7	73.8	8.4	47.6	20.6	18.6	7.1

Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2010 National Mental Health Services Survey (N-MHSS)

Note: More recent survey data, when it becomes available, should be assessed as Rhode Island has had shifts in treatment design since 2010. For instance, Rhode Island does not have Assertive Community Treatment as of 2011.

All Ages: Table 18 Percent of Total Mental Health Facilities Offering Treatment Programs or Groups Designed Exclusively for Specific Client Groups in New England and the United States, 2010

Location	Facilities responding, N ^a	Individuals With Co-occurring Mental and Substance Use Disorders	Individuals With Co-occurring Mental Health and Non-Substance Use Disorders	Individuals With Posttraumatic Stress Disorder	Individuals With Traumatic Brain Injury	Gay, Lesbian, Bisexual, or Transgender Clients	Forensic Clients (Referred From the Court/Judicial System)	Other
Rhode Island	67	68.7	46.3	52.2	3.0	13.4	40.3	7.5
Connecticut	182	65.9	43.4	54.9	17.0	28.0	35.7	8.8
Maine	110	61.8	31.8	41.8	10.0	20.0	18.2	3.6
Massachusetts	267	55.4	15.0	66.7	10.9	33.7	31.1	9.0
New Hampshire	62	45.2	46.8	58.1	16.1	27.4	32.3	14.5
Vermont	65	60.0	50.8	58.5	16.9	24.6	20.0	1.5
National	9,139	58.4	47.0	50.0	11.6	26.3	32.7	6.2

Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2010 National Mental Health Services Survey (N-MHSS)

Notes:

1. The N-MHSS includes facilities in the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and those operated by the Department of Veterans Affairs.

^a Of the 10,374 facilities in the N-MHSS, basic facility information, service characteristics, and client counts were reported for 9,139 facilities. The remaining 1,235 facilities are excluded from this table because their service characteristics were not reported.

**All Ages: Table 19 Percent of Mental Health
Facilities Accepting All Ages
for Treatment in New England
and the United States, 2010**

Location	Facilities responding, N^a	Accepting All Age Categories, %
Rhode Island	67	19.4
Connecticut	182	37.9
Maine	110	40.9
Massachusetts	267	40.8
New Hampshire	62	37.1
Vermont	65	29.2
National	9,139	43.3

Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2010 National Mental Health Services Survey (N-MHSS)

All Ages: Table 20

Mental Health Facilities That Employ a Crisis Intervention Team in New England and the United States, 2010

Location	Facilities Responding, N	Only Within Facility, %	Only Offsite, %	Both Within Facility and Offsite, %	No Crisis Intervention Team, %
Rhode Island	67	16.4	16.4	38.8	28.4
Connecticut	182	26.4	6.0	17.0	50.5
Maine	110	14.5	4.5	20.0	60.9
Massachusetts	267	23.6	12.0	12.7	51.3
New Hampshire	62	25.8	14.5	35.5	22.6
Vermont	65	13.8	40.0	33.8	12.3
National	9,139	23.6	10.4	23.9	41.6

Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2010 National Mental Health Services Survey (N-MHSS)

Notes:

1. Of the 10,374 facilities in the N-MHSS, basic facility information, service characteristics, and client counts were reported for 9,139 facilities. The remaining 1,235 facilities are excluded from this table because their service characteristics were not reported.
2. Of the 9,139 facilities that were given the standard questionnaire, having a crisis intervention team was unknown for 43 facilities (0.5%). Percentages may not sum to 100 because of rounding.

Ages 0–17 Years

0-17: Table 1 Pediatric Physicians (General, Total) per 100,000 Youth in New England and the United States, 2010–2012

Location	2010	2011	2012
Rhode Island	141.2	144.7	143.6
Connecticut	108.3	110.5	115.0
Maine	76.9	78.9	80.0
Massachusetts	144.8	144.1	143.8
New Hampshire	86.1	87.0	88.1
Vermont	130.6	129.6	130.1
National	75.2	76.7	77.9

Source: Area Resource File and Census population (aged 0–17 years) estimates for 2010, 2011, and 2012

0-17: Table 2 Child Psychiatric Physicians per 100,000 Population Aged 0–17 Years in New England and the United States, 2010–2012

Location	Total Patient Care			Office-Based			Hospital Full-Time Staff ^a		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
Rhode Island	19.7	19.1	22.6	11.2	11.8	14.3	3.1	2.7	2.8
Connecticut	20.9	23.2	26.0	15.0	16.1	18.0	2.8	3.0	3.0
Maine	15.4	16.0	15.9	12.5	13.0	13.2	1.5	1.5	1.9
Massachusetts	24.2	24.8	25.2	18.2	18.0	18.3	3.1	3.5	3.5
New Hampshire	10.5	12.8	15.6	8.8	10.7	12.3	0.0	0.4	0.7
Vermont	20.2	21.3	22.5	13.2	15.0	16.9	3.9	3.2	3.2
National	9.1	9.4	9.8	7.2	7.4	7.8	1.0	1.0	1.0

Source: Area Resource File and Census population (aged 0–17 years) estimates for 2010, 2011, and 2012

Notes:

^aHospital Full-Time Staff includes physicians employed under contract with hospitals to provide direct patient care, and excludes hospital residents.

0-17: Table 3

**Children and Adolescent
24-Hour Psychiatric Beds
in Rhode Island, 2015**

Hospital	24-Hour Beds
Bradley Hospital	60
Butler Adolescent Treatment Unit	11
Hasbro Children's Hospital	8
TOTAL	79

Source: Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) via personal communication on June 2nd, 2015.

Notes:

1. In 2012, Bradley Hospital, together with Hasbro Children's Hospital, opened an eight-bed medical-psychiatric IP unit for patients (aged 6–18 years) with both acute mental health and medical health conditions.
2. Butler Hospital has an Adolescent Treatment Unit that provides psychiatric treatment and support for teenagers, aged 13–17 years. Treatment programs are offered for depression, anxiety, addictions, and other mental illnesses.

0-17: Table 4 Substance Abuse Facilities, Clients Aged 0–17 Years, and Clients per Capita in New England and the United States, 2010–2012

Location	Clients Aged 0–17 Years, N			Facilities, N			Clients per 100,000 Population, N		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
Rhode Island	496	1,006	323	53	59	63	222	458	149
Connecticut	555	612	493	195	188	223	68	76	62
Maine	752	703	1033	179	213	223	275	262	390
Massachusetts	1,948	1,312	2,343	138	93	167	138	93	167
New Hampshire	431	441	433	52	54	59	151	157	157
Vermont	399	330	351	42	42	43	310	261	282
National	81,863	82,532	89,521	13,339	13,720	14,311	110	112	121

Source: National Survey on Substance Abuse Treatment Services (N-SSATS)

0-17: Table 6 Residential Treatment Centers (RTCs) for Children in New England and the United States, 2010

Location	RTCs for Children, N	RTCs for Children per 100,000 Children, N
Rhode Island	5	2
Connecticut	11	1
Maine	20	7
Massachusetts	69	5
New Hampshire	15	5
Vermont	9	7
National	781	1

Source: 2010 National Mental Health Services Survey (N-MHSS).

0-17: Table 7 Mental Health Facilities Offering Treatment Programs or Groups Designed Exclusively for Youth With Serious Emotional Disturbance in New England and the United States, 2010

Location	Facilities, N	Mental Health Facilities in the State, %
Rhode Island	22	33
Connecticut	71	39
Maine	40	36
Massachusetts	137	51
New Hampshire	32	52
Vermont	23	35
National	3,944	43

Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2010 National Mental Health Services Survey (N-MHSS)

Notes:

1. The N-MHSS includes facilities in the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and those operated by the Department of Veterans Affairs.
2. Of the 10,374 facilities in the N-MHSS, basic facility information, service characteristics, and client counts were reported for 9,139 facilities. The remaining 1,235 facilities were excluded from this table because their service characteristics were not reported.

0-17: Table 8 Mental Health Facilities Accepting Youth-Only Treatment in New England and the United States, 2010

Location	Facilities, N	Mental Health Facilities in the State, %
Rhode Island	10	15
Connecticut	32	18
Maine	11	10
Massachusetts	38	14
New Hampshire	9	15
Vermont	6	9
National	1,147	13

Source: 2010 National Mental Health Services Survey (N-MHSS)

Key Points:

1. Of mental health facilities responding, Rhode Island had 10 facilities that accepted youth only (17 years and younger) in 2010.
2. Of mental health facilities responding, the percentage accepting youth only (17 years and younger) in Rhode Island in 2010 fell approximately in the middle range of New England states (9.2%–17.6%) and was slightly higher than the national percentage (12.6%)

**0-17: Table 9 Residential Treatment Center
Mental Health Organizations
for Children With Severe
Emotional Disturbance in New
England and the United
States, 2008**

Location	N
Rhode Island	2
Connecticut	9
Maine	4
Massachusetts	33
New Hampshire	8
Vermont	7
National	551

Source: Substance Abuse and Mental Health Services Administration. (2012). Mental Health, United States, 2010. HHS Publication No. (SMA) 12-4681. Rockville, MD: Substance Abuse and Mental Health Services Administration. Tables 110, 116, 117, and 118.

0-17: Table 10 Mental Health Services Offered to Children Under Medicaid (out of Total Available Services) in New England States, Fiscal Year 2008

Location	Of 11 EBP MH Services, N Offered	Of 13 MH Rehab Services, N Offered	Of 10 Clinical MH Services, N Offered
Rhode Island	1	1	5
Connecticut	9	8	8
Maine	6	3	7
Massachusetts	4	2	8
New Hampshire	1	1	3
Vermont	4	3	4

Source: Mental Health Association of Rhode Island, Mental Health Measures (December 2013) (Mental Health, United States, 2010, Table 107.
http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/MHARI_Mental_Health_Measures_final.pdf, accessed February 25, 2015)

Abbreviations: EBP, evidence-based practices; MH, mental health

0-17: Table 11 Rhode Island Department of Children, Youth, and Families, December Point-in-Time Instate Licensed Bed Numbers, 2011 - 2014

Agency	Facility	Program Type	Age Range	2011 Licensed Capacity	2012 Licensed Capacity	2013 Licensed Capacity	2014 Licensed Capacity
Action Based Enterprises	Action Based Enterprises	Supervised Apartment	16-21	3	N/A	N/A	N/A
Boys Town of New England	Girls and Boys Town	Shelter	5-11	8	7	7	7
Boys Town of New England	Girls and Boys Town	Group Home	10-18	7	7	7	7
Boys Town of New England	Girls and Boys Town	Group Home	10-18	8	8	8	8
Boys Town of New England	Girls and Boys Town	Group Home	10-18	8	7	7	7
Bradley Hospital	Craft Program	Group Home/RCC	5-12	18	18	18	18
Bradley Hospital	Exeter House	Residential Treatment Center	9-18	N/A	N/A	8	8
Bradley Hospital	Heritage House	Group Home	12-21	8	8	8	8
Bradley Hospital	Hill House	Group Home	12-21	8	N/A	8	8
Bradley Hospital	Rumford House	Group Home	12-21	8	8	8	8
Child and Family Services	Child and Family Services	Group Home/RCC	6-12	8	8	5	6
Child and Family Services	Child and Family Services	Group Home	12-17	4	N/A	N/A	N/A
Child and Family Services	Child and Family Services	Group Home	7-12	8	8	8	8
Child and Family Services	Child and Family Services	Semi-ILP	15-18	4	4	5	0
Child and Family Services	Child and Family Services	Group Home	8-13	8	8	8	8
Child and Family Services	Child and Family Services	Semi-ILP	16-18	4	5	N/A	N/A
Child and Family Services	Child and Family Services	Semi-ILP	16-18	4	8	5	0
Child and Family Services	Child and Family Services	Staff Secure	13-17	8	5	8	8
Child and Family Services	Child and Family Services	Group Home	12-17	4	8	N/A	N/A
Child and Family Services	Child and Family Services	Semi-ILP	16-18	4	8	5	6
Child and Family Services	Child and Family Services	Staff Secure	12-18	8	8	8	8
Child and Family Services	Child and Family Services Network	Group Home	12-16	8	8	8	8
Children's Shelter of Blackstone Valley, Inc.	Children's Shelter of Blackstone Valley, Inc.	Shelter	0-12	8	8	8	8
Communities for People, Inc.	Communities for People	Supervised Apartment	16-20	4	4	8	8
Communities for People, Inc.	Communities for People	Supervised Apartment	16-21	7	8	N/A	N/A
Communities for People, Inc.	Communities for People	Shelter	13-17	5	N/A	5	6
Communities for People, Inc.	Communities for People	Supervised Apartment	16-21	7	8	8	8
Communities for People, Inc.	Communities for People	Shelter	13-17	7	7	8	8
Communities for People, Inc.	Communities for People	Group Home/Supervised Apartment	16-20	6	6	11	8
Communities for People, Inc.	Communities for People	Supervised Apartment	16-21	11	11	N/A	N/A
Communities for People, Inc.	Communities for People	Specialized Group Home	16-20	8	8	8	8
Community Solutions, Inc.	Community Solutions	Group Home	12-17	8	8	8	8
Community Solutions, Inc.	Community Solutions	Residential Treatment Center	12-18	8	8	N/A	N/A
Comprehensive Community Action Program (CCAP)	New Opportunities Home	Group Home	N/A	N/A	6	6	4
Cranston Community Action Program (CCAP)	New Opportunities Home	Group Home	N/A	N/A	4	4	4
FACTS House	FACTS House	Shelter	0-5	8	N/A	N/A	N/A
Family Services of Rhode Island	Farnum Road	Staff Secure	12-17	8	8	8	8
Family Services of Rhode Island	Greenville House	Staff Secure	12-18	8	8	8	8
Family Services of Rhode Island	Sakonnet House	Shelter	12-15	8	8	8	8
Family Services of Rhode Island	Tzwapi House	Semi-ILP	15-18	6	N/A	N/A	N/A
Family Services of Rhode Island	Wilson House	Group Home	12-18	8	8	8	8
Gateway Healthcare, Inc.	Arcadia House	Group Home/RCC	6-11	14	14	10	10
Gateway Healthcare, Inc.	Blackstone Adolescent Center	Residential Counseling Center	12-18	9	9	9	9

0-17: Table 11, Cont'd. Rhode Island Department of Children, Youth, and Families, December Point-in-Time Instate Licensed Bed Numbers, 2011 - 2014

Agency	Facility	Program Type	Age Range	2011 Licensed Capacity	2012 Licensed Capacity	2013 Licensed Capacity	2014 Licensed Capacity
Gateway Healthcare, Inc.	Blackstone Children's Home	Group Home/RCC	5-12	8	N/A	N/A	N/A
Gateway Healthcare, Inc.	Lighthouse for Youth	Group Home	13-18	5	5	5	5
Gateway Healthcare, Inc.	Lighthouse for Youth	Semi-ILP	14-18	4	0	N/A	N/A
Gateway Healthcare, Inc.	Lincoln House	Group Home/RCC	12-18	9	9	9	9
Groden Center	Badger Roadf	Group Home	12-18	N/A	N/A	N/A	3
Groden Center	Branch Pike	Residential Treatment Center	12-21	5	5	5	6
Groden Center	Farnum Pike	Residential Treatment Center	12-21	7	7	7	7
Groden Center	Rome Ave.	Residential Treatment Center	12-21	5	5	5	5
Harmony Hill	Harmony Hill	Residential Treatment Center	13-18	61	61	61	61
North American Family Institute	ACE	Residential Treatment Center	12-18	21	18	18	18
North American Family Institute	Alternatives	Residential Treatment Center	13-18	26	N/A	N/A	N/A
North American Family Institute	NAFI Main Street	Group Home	13-17	8	8	8	8
North American Family Institute	NAFI Ridge	Group Home	13-18	8	8	8	8
North American Family Institute	Oakland Beach	Group Home	12-18	8	8	8	8
Ocean Tides	Naragansett	Residential Treatment Center	13-18	35	35	35	26
Ocean Tides	Gallgoly House	Group Home	13-17	8	8	8	N/A
Ocean Tides	Hillside	Group Home	13-18	8	N/A	N/A	N/A
Ocean Tides	Pullman	Group Home	13-19	6	6	N/A	N/A
Perspectives Corporation	Perspectives Corporation Sandturn House	Residential Treatment Center	14-17	8	8	8	8
Phoenix Academy of New England	Phoenix Academy	Shelter	13-18	14	14	14	16
St. Mary's Home for Children	St. Mary's Home for Children - Hills Unit	Shelter	12-17	8	8	8	8
St. Mary's Home for Children	St. Mary's Home for Children - Horton Unit	Residential Treatment Center	12-18	10	10	10	10
St. Mary's Home for Children	St. Mary's Home for Children - Mauran Unit	Residential Treatment Center	6-13	8	8	8	8
Tanner Hill, Inc.	Tannerhill, Inc.	Group Home	5-12	8	8	8	6
Tannerhill Inc.	Tannerhill	Group Home	5-12	8	8	6	8
The Key Program	Key Program	Shelter	13-17	10	10	9	9
The Key Program	Key Program	Residential Counseling Center/ Semi-ILP	16-20	8	5	5	5
Turning Point	Turning Point	Semi-ILP	16-18	3	3	3	3
Turning Point		Group Home	12-17	8	8	8	8
Turning the Corner	Lewis Bey House	Shelter	12-17	8	N/A	N/A	N/A
Turning the Corner	Star House	Group Home	12-17	8	8	8	8
Turning the Corner	Turning the Corner	Group Home	13-18	8	8	8	8
Turning the Corner	Turning the Corner	Group Home	13-18	8	8	8	8
Turning the Corner	Turning the Corner	Shelter	13-17	8	8	8	8
Turning the Corner	Turning the Corner	Group Home	14-20	4	4	8	8
Washington Park Children's Shelter	Washington Park Children's Shelter	Shelter	0-12	8	8	N/A	N/A
Whitmarsh Corporation	Whitmarsh Corporation	Supervised Apartment	16-20	5	5	5	6
Whitmarsh Corporation	Whitmarsh Corporation	Residential Treatment Program	12-18	8	8	8	8
Whitmarsh Corporation	Whitmarsh Corporation	Group Home	12-15	8	8	6	6
Whitmarsh Corporation	Whitmarsh Corporation	Group Home	15-20	4	N/A	N/A	N/A
Whitmarsh Corporation	Whitmarsh Corporation	Group Home	14-16	6	6	6	N/A
Whitmarsh Corporation	Whitmarsh Corporation	Group Home	14-17	5	5	5	5
Whitmarsh Corporation	Whitmarsh Corporation	Specialized Semi-ILP	17-21	5	5	5	5
Whitmarsh Corporation	Whitmarsh Corporation	Group Home	16-18	8	8	8	0
Youth Services International	Athena Circle	Group Home/Residential Treatment Program	12-17	15	N/A	N/A	N/A

Source: Rhode Island Department of Children, Youth, and Families. Obtained via personal communication with Christopher Strnad, Administrator, on April 7th, 2015.

Ages 18+ Years

18+: Table 1 Suboxone-Waived Physicians and Treatment Programs in New England and the United States, 2015

Location	Physicians		Treatment Programs	
	N (Total)	N per 100,000 Adults	N (Total)	N per 100,000 Adults
Rhode Island	100	11.9	21	2.5
Connecticut	320	11.4	46	1.6
Maine	120	11.2	37	3.5
Massachusetts	682	12.9	72	1.4
New Hampshire	60	5.7	11	1.0
Vermont	42	8.3	11	2.2
National	N/A	N/A	N/A	N/A

Source: Totals were from Substance Abuse and Mental Health Services Administration, Buprenorphine Physician and Treatment Program Locator. buprenorphine.samhsa.gov/pls/bwns_locator/. Accessed February 19, 2015. Totals per 100,000 adults were derived from population estimates from census.gov as of July 1, 2013. for adults aged 18 years and older.

Note:

1. Data from previous years are not available on the above website. Therefore, only current data are included.

18+: Table 2

**Clients in SUD Treatment in New England and the United States,
2010–2012**

Location	2010		2011		2012	
	Clients, N	Clients per 100,000 Adults, N	Clients, N	Clients per 100,000 Adults, N	Clients, N	Clients per 100,000 Adults, N
Rhode Island	7,362	831	9,742	1,050	8,499	980
Connecticut	28,247	1,022	25,850	462	36,496	1,288
Maine	10,593	940	10,757	951	12,884	1,114
Massachusetts	39,444	727	46,879	879	45,219	818
New Hampshire	5,237	464	5,931	529	5,946	528
Vermont	4,489	825	4,181	771	4,023	731
National	1,172,841	462	1,221,297	473	1,237,133	478

Source: National Survey on Substance Abuse Treatment Services (N-SSATS), which is an annual census of all substance abuse treatment facilities in the United States, both public and private

Notes:

1. Clients in treatment were measured as of March 31 of each year.

18+: Table 3

SUD Treatment Facilities for Adult Women and Men in New England and the United States, 2010–2012

Location/Program	2010		2011		2012	
	N	%	N	%	N	%
Rhode Island						
Adult women	16	30.2	21	35.6	18	28.6
Adult men	13	24.5	9	15.3	12	19.0
Connecticut						
Adult women	95	48.7	85	45.2	115	51.6
Adult men	77	39.5	68	36.2	90	40.4
Maine						
Adult women	26	14.5	38	17.8	35	15.7
Adult men	26	14.5	29	13.6	31	13.9
Massachusetts						
Adult women	105	34.2	113	35.1	116	35.4
Adult men	96	31.3	98	30.4	109	33.2
New Hampshire						
Adult women	16	30.8	15	27.8	20	33.9
Adult men	14	26.9	13	24.1	13	22.0
Vermont						
Adult women	17	40.5	18	42.9	16	37.2
Adult men	13	31	11	26.2	9	20.9
National						
Adult women	4239	31.8	4322	31.5	4,470.0	31.2
Adult men	3376	25.3	3367	24.5	3,550.0	24.8

Source: National Survey on Substance Abuse Treatment Services (N-SSATS), which is an annual census of all substance abuse treatment facilities in the United States, both public and private.

Notes:

1. N-SSATS attempts to obtain responses from all known treatment facilities, but it is a voluntary survey. There is no adjustment for the approximately 4 percent facility non-response.

18+: Table 4

Agencies Licensed by BHDDH to Provide Substance Abuse Treatment Services in Rhode Island, 2015

Program	Agency	Population Type	Detailed Location
TOTAL AGENCIES		24	
Detoxification Services			
	Adcare	Inpatient	Adcare Rhode Island, Inc.
	Phoenix Houses of New England, Inc.	Inpatient	
	Gateway Healthcare, Inc.	Outpatient	
	Clinical Services or RI, Inc.	Outpatient	3 locations
Residential Treatment Services			
	Adcare	Not Specific	Adcare Rhode Island, Inc.
	Gateway Healthcare, Inc.	Adolescent Females	Caritas House
		Adult Women	Eastman
		Adult Women	King House
		Adult Men	Men's House
	Galilee House	Adult Men	
	Bridgemark, Inc.	Adult Men	
	MAP Behavioral Health Services, Inc.	Adult Men	
	Phoenix Houses of New England, Inc.	Adult Women	Ottmar Building
		Adult Men	Ladd Campus
		Adolescent Males	Wallum Lake
	The Providence Center	Adult Women	Roads to Recovery
		Adult Men	Roads to Recovery
		Not Specific	Symmetry at Duncan Lodge
	SSTARBIRTH	Pregnant/Post-Partum Women	
Community Care Alliance	Adult Men	Robert J. Wilson House	
Outpatient Services			
	Adcare	Not Specific	Adcare Rhode Island, Inc.
		Not Specific	Adcare Hospital of Worcester
	Gateway Healthcare, Inc.	Adolescents	Caritas House
		Not Specific	4 locations
	Child & Family Services of Newport County	Not Specific	
	Clinical Services or RI, Inc.	Not Specific	3 locations
	Codac	Not Specific	5 locations
	Comprehensive Community Action Addiction Services	Not Specific	
	Discovery House	Not Specific	2 locations
	East Bay Center	Not Specific	2 locations
	Community Care Alliance	Not Specific	2 locations
	Family Services of Rhode Island	Not Specific	2 locations
	Galilee Mission	Not Specific	
	The Kent Center	Not Specific	
	Bridgemark, Inc.	Not Specific	
	MAP Behavioral Health, Inc.	Not Specific	
	Continuum Behavioral Health	Not Specific	
	Medical Assisted Recovery, Inc.	Not Specific	
	Newport County Community Mental Health Center	Not Specific	
	Phoenix Houses of New England, Inc.	Not Specific	3 locations
The Providence Center	Not Specific		
Tri-Town Substance Abuse Treatment Services	Not Specific	2 locations	
Narcotic Treatment Services			
	Addiction Recovery Institute	Not Specific	2 locations
	The Journey to Hope, Health, and Healing, Inc.	Not Specific	3 locations
	Codac	Not Specific	4 locations
	Center for Treatment and Recovery	Not Specific	
	Discovery House	Not Specific	2 locations

Source: BHDDH. Agencies Licensed to Provide Substance Abuse Treatment Services. Last updated 1-5-2015. Accessed April 15th, 2015 at http://www.bhddh.ri.gov/SA/pdf/BHDDH-Licensed%20Substance%20Abuse%20Agencies%20for%20External%20Database%20%28revised%201-5-15%29_1.pdf?513.

18+: Table 5 Residential Treatment Centers (RTCs) for Adults in New England and the United States, 2010

Location	RTCs for Adults, N	RTCs for adults per 100,000 Adults^a
Rhode Island	23	2.8
Connecticut	19	0.7
Maine	30	2.8
Massachusetts	23	0.4
New Hampshire	7	0.7
Vermont	23	4.6
National	875	0.4

Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2010 National Mental Health Services Survey (N-MHSS)

Note:

^aDerived from 2010 Census data (ages 18+ years)

18+: Table 6 Percent of Total Mental Health Facilities Offering Exclusively Designed Treatment Programs for Select Adult Groups in New England and the United States, 2010

Location	Mental Health Facilities Offering Exclusively Designed Treatment, %			
	Transition-Aged Young Adults Aged 18–25 Years	Adults With Serious Mental Illness	Individuals with Alzheimer's or Dementia	Veterans
Rhode Island	22	57	6	12
Connecticut	31	50	7	22
Maine	25	55	6	14
Massachusetts	35	48	11	18
New Hampshire	37	53	18	26
Vermont	37	55	12	17
National	30	63	13	23

Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2010 National Mental Health Services Survey (N-MHSS)

**18+: Table 7 Percent of Total Mental Health Facilities
Offering Treatment Programs for Select
Adult Age Groups in New England and the
United States, 2010**

Location	Adults Only (0-64 Years), N	Adults and Seniors (18+ Years), N	Seniors Only (65+ Years), N
Rhode Island	9.0	52.2	0.0
Connecticut	2.2	32.4	0.5
Maine	1.8	32.7	0.9
Massachusetts	6.4	21.3	1.9
New Hampshire	4.8	27.4	4.8
Vermont	1.5	46.2	0.0
National	4.8	30.0	1.7

Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2010 National Mental Health Services Survey (N-MHSS)

18+: Table 8

**Mental Health Psychiatric
Rehabilitative Residences
(MHPRRs) in Rhode Island, 2015**

Facility	Total Beds, N	Group Home Beds, N	Supervised Apartments, N
TOTAL	381	264	117
East Bay	18	18	0
Gateway	95	51	44
Kent Center	37	21	16
Newport	14	14	0
NRI	41	23	18
Providence Center	99	60	39
South Shore	22	22	0
Fellowship Health Resources	21	21	0
Riverwood	29	29	0
North American Family Institute (NAFI)	5	5	0

Source: Kristine Medeiros, Rhode Island Department of Behavioral Healthcare (BHDDH), via personal communication on January 20th, 2015.

Notes:

1. There are 10 MHPRRs in a total of 32 locations with a total of 381 beds.
2. NRI is also known as Community Care Alliance.

18+: Table 9 Housing Vouchers Issued in Rhode Island to Veterans and to All Adults (by Housing First), Fiscal Years 2010–2015

Voucher Type	Vouchers Issued to Adults by Housing First, N					Vouchers Issued to Veterans, N			
	2010	2011	2012	2013	2014	2012	2013	2014	2015 so far (10/1/2014–2/1/2015)
Subsidized units (housing vouchers)	135	135	146	157	151	68	30	49	28
Shelter Plus Care	55	55	61	72	61	N/A	N/A	N/A	N/A
Road Homes	80	80	85	85	85	N/A	N/A	N/A	N/A
State Rental Assistance Program	0	0	0	0	4	N/A	N/A	N/A	N/A

Source: Overall numbers were obtained from Don Boucher from Housing First (Riverwood Mental Health Services) via personal communication, February 26, 2015. Data on vouchers issued to veterans were obtained from Bob Tildon at the Rhode Island Veterans Administration, personal communication, February 2, 2015.

Notes:

1. Housing First placements have been concentrated in Huntington Towers, Charles Gate Apartments, and 1890 House.
2. The number of vouchers provided by Rhode Island to the Veterans Administration over the last 3 fiscal years is 55. The Veterans Administration is able to issue more than the 55 vouchers provided in Rhode Island because of the turnover of vouchers by the veterans for various reasons.