Rhode Island Behavioral Health System of Care for Children and Youth
DRAFT Plan – October 2021

DRAFT for Community Review

Released for Comment October 5, 2021

Executive Summary

Rhode Island children, youth, and families are facing a behavioral health crisis that is not being adequately addressed by our current structure. This Rhode Island Behavioral Health System of Care for Children and Youth plan lays out the challenges before us and this letter serves as the Executive Summary.

Our state planning team and our community partners – families, providers of services, and advocates – have identified four components of the crisis:

- Population level challenges – including structural racism and the inequities of the ability of all Rhode Island families to access appropriate Social Determinants of Health.
- Mental health and substance use conditions affecting children, youth, and families that are rising in scope and severity over the past number of years.
- COVID, which has had an enormous impact on our Rhode Island families and their children, because of isolation, school closures, economic challenges, and grief and loss
- The inadequacy of the Rhode Island behavioral health system – which, underfunded for years, has led to workforce shortages, siloed state agency approaches and policies, and waiting lists that leave families at risk.

This document includes quantitative and qualitative data showing the impact of the crisis on behavioral health metrics such as anxiety and depression, eating disorders, trauma, grief and loss, and suicidality – as well as on our behavioral health system's inability to serve the rising need. This need presents differently for boys and young men than it does for girls and young women and potentially for youth who are non-binary - and this need is even greater for our children, youth, and families of color. Every metric shows that these youth are at higher risk and need more investment to reach equity alongside their white counterparts. Then, we provide specific goals and objectives to frame a coordinated System of Care to address the challenges.

Our government and private partners have the opportunity to take important, specific steps to improve the system. This plan proposes to begin with a focus on the system for families in crisis, including adding capacity to mobile crisis and our intensive Home and Community-Based Services and its workforce. We must also invest in prevention services and the integration of behavioral of health into the primary pediatric and young adult healthcare system. This will help improve families' quality of life – and avoid restrictive and expensive care.

With the potential of funding available from the recently passed American Rescue Plan, we have a once in a generation opportunity to accomplish these changes now. Our families deserve a true ***System of Care*** for mental health and substance use conditions that exists in a coordinated arrangement that is easy to navigate, that provides high quality care, that meets individual needs, that recognizes and addresses historical structural racism and other disparities, and that the state sustains financially and administratively.

For this newly structured System of Care plan, which is a living document and will continuously adapt, we seek to strengthen the partnership among communities, youth, families, schools, government, and provider agencies that improves outcomes, increases access to services and supports, and promotes positive change in families' lives.

Here is our call to action for parents, community leaders, providers, policymakers, philanthropists, and others:

- If you need services for yourself or your child, or know someone who does, please get in touch with the resources listed in this plan. We want to help, and we'd also like your input on how the system works or does not work for you.
- We are seeking Champions to continue to help design this System plan – and to invite you to support the adoption and evolution of the document. We encourage you to participating in ongoing planning groups, help spread the word to families, and provide critical feedback on what else the state can do to improve the system.
- We thank all care providers for your work on behalf of Rhode Island children, and invite you to comment on and participate in the ongoing review of the system. This includes both physical healthcare providers, such as pediatricians and family practice providers, and behavioral health providers.
- To build parts of the new system, we will need policy changes, and look forward to working with policymakers and advocates to make that happen.
- We will be seeking significant investments in our children and youth and look forward to working with community members and the philanthropy community to achieve them - because those investments will last a lifetime.

Acknowledgements

The Rhode Island Executive Office of Health and Human Services (EOHHS) is grateful for the work of so many people, including community partners and state agency staff, who contributed to this draft Plan.

The Child Well Being Planning Team appreciates the work of our family and health-focused state agency leadership in supporting this planning process:

Secretary Womazetta Jones, Executive Office of Health and Human Services
Assistant Secretary Ana Novais, Executive Office of Health and Human Services
Director Benjamin Shaffer, Rhode Island Medicaid
Director Richard Charest, Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals
Acting Director Kevin Aucoin, Department of Children, Youth, and Families
Commissioner Angélica Infante-Green, Department of Education
Director Nicole Alexander-Scott, MD, Department of Health
Acting Director Celia Blue, Department of Human Services
Commissioner Patrick M. Tigue, Office of the Health Insurance Commissioner
Rosa De Castillo, Director of Community Affairs and Outreach, Office of Governor Daniel McKee

We are especially grateful to the Community Co-Chairs who partnered with State Staff to lead our eight Work Groups:

Care Coordination – Jessica Waugh, Community & Home Therapeutic Services Director, Groden Center with Chris Strnad, DCYF

Community Outreach and Education – Naiommy Baret, Parent Support Network with Marti Rosenberg and Ashley O'Shea, EOHHS

Crisis Continuum – **Mobile Response and Stabilization Services/Single Point of Access** – Kayla David, LMFT, Family Service of Rhode Island with Susan Lindberg, DCYF

Data Systems for Outcome Measurement & Evaluation – Benjamin Weiner, Family Service of Rhode Island with Annice M. Correia Gabel and Kim Paull, EOHHS

Ensuring Equity – Jesse Hunter, Community Provider Network of Rhode Island, with Jordan Maddox, BHDDH and James Rajotte, EOHHS

Prevention – Dr. Tammie-Marie Phillip, Butler Hospital with James Rajotte, EOHHS

Service Array – Nidhi Turner, MSW, LICSW, Northeast Family Services with Jason Lyon, EOHHS/Medicaid

Workforce Transformation – Rick Brooks, EOHHS

EOHHS also thanks two of our key staff, Charlotte Kreger and Ellie Rosen, and our summer intern, Maayan Rosenfield, for their hard work and commitment to improving the lives of Rhode Island's children, youth, and families.

Table of Contents

Vision – Rhode Island Behavioral Health System of Care for Children and Youth

We envision a partnership among communities, youth, families, schools, pediatricians, government, and provider agencies that improves outcomes, increases access to services as supports, and promotes positive change in the lives of children and their families.

This vision stems from the Executive Office of Health and Human Services' (EOHHS's) values of Choice, Race Equity, and Community Engagement – and our key priorities:

1 – Preserving and improving access to quality, cost-effective healthcare
2 – Shifting systems and investments to prevention, value, choice, and equity
3 – Curbing the Opioid Epidemic and improving mental health services
4 – Promoting efficient, effective, and fair delivery of services.

How will we know if we have succeeded? Right now, Rhode Island ranks 33rd in overall child behavioral health outcomes, with high rates of illicit drug use, alcohol use, and anxiety compared to other states. In the majority of behavioral health metrics, Rhode Island ranks worse than the US average (America's Health Rankings).

We must commit to raising Rhode Island to the top of the United States with the metrics where we are low and stay at the top of the ones where we are high. We do have the tools to accomplish this. We have created a strong state interagency team that is working with a broad public/private group of community partners within eight Work Groups. We have the potential of funding from the American Rescue Plan. We have begun the difficult conversations necessary to take on the structural racism that underscores many of the challenges described within these pages. And we have the commitment from state agency leadership to make the changes that we need.

Rhode Island must also recognize and capitalize upon our strengths. In 2020, 73.3% of children under 18 met the definition for "flourishing" compared to 71.7% nationwide. In 2020, Rhode Island was the state with the lowest rate of teen deaths by suicide (5/100,000).[i]

This plan begins with a description of a Behavioral Health System of Care for Children and Youth (SOC), including the national System of Care principles. Then, the plan lays out Rhode Island's Problem Diagnosis, backed up by data. On Page 33, we present our Rhode Island Theory of Change. The specific System of Care plan components start on Page 38, including specific detailed activities, metrics, and potential barriers, for each component. The Plan ends with a timeline, governance structure for moving forward, and a path for creating a funding and sustainability plan.

What is a System of Care?

A "System of Care" is an organizational framework, not a prescriptive model. It includes:

- A wide continuum of effective, community-based services and supports that is organized into a culturally competent, coordinated network that meets the needs of all families.
- A set of principles to guide the way services and supports are provided to children and families that include interagency collaboration; individualized strengths-based care; cultural competence; child, youth, and family involvement; community-based services; and accountability.
- Numerous evaluations have found that systems of care are associated with a range of positive outcomes:
    - For example, in the federal Substance Abuse and Mental Health Services Administration (SAMHSA) 2009 annual national report to Congress it was reported that systems of care resulted in positive outcomes for children and families and that they are effective in improving services and better investment of limited resources.

According to the Child Welfare Information Gateway, systems of care approach stemmed from a 1984 Child and Adolescent Services System Program (CASSP), to help states plan for and design strategies to address the mental health of children experiencing serious emotional disturbances.

The System of Care approach was originally created in response to concerns that[ii]:

- Children in need of mental health treatment were not getting the services they needed
- Services were often provided in restrictive out-of-home settings
- Few community-based services were available
- Service providers did not work together
- Families were not adequately involved in their child's care
- Cultural differences were rarely taken into account

Systems of care began to address mental health issues and were then applied to children and youth in the child welfare system. Rhode Island is planning to implement the system framework for all Rhode Island children.

System of Care: Values and Principles[iii]

Core Values	Systems of Care are:
1. Family and Youth Driven	Family and youth driven, with families and young people supported in determining the types of treatment and supports provided (with increasing youth/young adult self-determination based on age and development), and their involvement in decision-making roles in system-level policies, procedures, and priorities.
2. Community Based	Community based, with services and supports provided in home, school, primary care, and community settings to the greatest possible extent, and with responsibility for system management and accountability resting

	within a supportive, adaptive infrastructure of structures, processes, and relationships at the community or regional level.
3. Culturally and Linguistically Competent	Culturally and linguistically responsive, with agencies, services, and supports adapted to the cultural, racial, ethnic, and linguistic diversity of the young people and families they serve to provide care that meets individual needs, including those shaped by culture and language, and to ensure equity in access, quality, and effectiveness of services
Guiding Principles	**Systems of Care are Designed to:**
1. Comprehensive Array of Services and Supports	Ensure availability and access to a broad, flexible array of effective, high-quality treatment, services, and supports for young people and their families that address their emotional, social, educational, physical health, and mental health needs, including natural and informal supports.
2. Individualized, Strengths-Based Services and Supports	Provide individualized services and supports tailored to the unique strengths, preferences, and needs of each young person and family that are guided by a strengths-based planning process and an individualized service plan developed in partnership with young people and their families.
3. Evidence-Based Practices and Practice- 4. Based Evidence	Ensure that services and supports include evidence-informed, emerging evidence-supported, and promising practices to ensure the effectiveness of services and improve outcomes for young people and their families, as well as interventions supported by practice-based evidence provided by diverse communities, professionals, families, and young people.
5. Trauma-Informed	Provide services that are trauma-informed, including evidence-supported trauma-specific treatments, and implement system-wide policies and practices that address trauma.
6. Least Restrictive Natural Environment	Deliver services and supports within the least restrictive, most natural environments that are appropriate to the needs of young people and their families, including homes, schools, primary care, outpatient, and other community settings.
7. Partnerships with Families and Youth	Ensure that family and youth leaders and family- and youth-run organizations are full partners at the system level in policy, governance, system design and implementation, evaluation, and quality assurance in their communities, states, tribes, territories, and nation.
8. Interagency Collaboration	Ensure that services are coordinated at the system level, with linkages among youth-serving systems and agencies across administrative and funding boundaries (e.g., education, child welfare, juvenile justice, substance use, primary care) and with mechanisms for collaboration, system-level management, and addressing cross-system barriers to coordinated care.
9. Care Coordination	Provide care coordination at the service delivery level that is tailored to the intensity of need of young people and their families to ensure that multiple services and supports are delivered in a coordinated and therapeutic manner and that they can move throughout the system of services and supports in accordance with their changing needs and preferences.

10. Health-Mental Health Integration	Incorporate mechanisms to integrate services provided by primary health care and mental health service providers to increase the ability of primary care practitioners and behavioral health providers to better respond to both mental health and physical health problems.
11. Developmentally Appropriate Services and Supports	Provide developmentally appropriate services and supports, including services that promote optimal social-emotional outcomes for young children and their families and services and supports for youth and young adults to facilitate their transition to adulthood and to adult service systems as needed.
12. Public Health Approach	Incorporate a public health approach including mental health promotion, prevention, early identification, and early intervention in addition to treatment in order to improve long-term outcomes, including mechanisms in schools and other settings to identify problems as early as possible and implement mental health promotion and prevention activities directed at all children, youth, and young adults and their families.
13. Mental Health Equity	Provide equitable services and supports that are accessible to young people and families irrespective of race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socioeconomic status, geography, language, immigration status, or other characteristics; eliminate disparities in access and quality of services, and ensure that services are sensitive and responsive to all individuals.
14. Data Driven and Accountability	Incorporate mechanisms to ensure that systems and services are data-driven, with continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of goals; fidelity to SOC values and principles; the utilization and quality of clinical services and supports; equity and disparities in service delivery; and outcomes and costs at the child and family and system levels.
15. Rights Protection and Advocacy	Protect the rights of young people and families through policies and procedures and promote effective advocacy efforts in concert with advocacy and peer-led organizations.

Definitions of Key Terms
Here are the definitions of a number of key terms found in this document. A full list of acronyms can be found in Appendix 4.

Health and Behavioral Health: First, we want to define health and behavioral health. When EOHHS talks about health, we always mean physical health, behavioral health, and oral health together. When we say behavioral health, we mean both mental health and treatment for substance use conditions.

Addiction: The American Society Addiction Medicine (ASAM) defines addiction as a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations.

Adverse childhood experiences (ACEs): Potentially traumatic events that occur in childhood (0-17 years). For example:

- experiencing violence, abuse, or neglect
- witnessing violence in the home or community
- having a family member attempt or die by suicide

Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with:

- substance use problems
- mental health problems
- instability due to parental separation or household members being in jail or prison

ACEs are linked to chronic health problems, mental illness, and substance use problems in adulthood. ACEs can also negatively impact education, job opportunities, and earning potential. However, ACEs can be prevented.

Please note the examples above are not meant to be a complete list of adverse experiences. There are many other traumatic experiences that could impact health and wellbeing. Preventing Adverse Childhood Experiences |Violence Prevention|Injury Center|CDC

All Rhode Island Families: In this System of Care plan, when we talk about all Rhode Island children and families, we mean children and families throughout the state, not just those in the child welfare system and not just those receiving Medicaid.

Behavioral Health Crisis: "…any situation in which a person's behavior puts them at risk of hurting. themselves or others and/or prevents them from. being able to care for themselves or function. effectively in the community. (National Association of Mental Illness [NAMI])

NAMI Minnesota further defines it as, "...a behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of

functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including but not limited to, inpatient hospitalization."

Child and Adolescent Needs and Strengths (CANS): A multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Versions of the CANS are currently used in 50 states in child welfare, mental health, juvenile justice, and early intervention applications. The Child and Adolescent Needs and Strengths (CANS) – Praed Foundation

Certified Community Behavioral Health Clinic (CCBHC): A CCBHC represents an opportunity for states to improve the behavioral health of their citizens by: providing community-based mental and substance use disorder services; advancing integration of behavioral health with physical health care; assimilating and utilizing evidence-based practices on a more consistent basis; and promoting improved access to high quality care. Care coordination is the linchpin holding these aspects of CCBHC care together and ensuring CCBHC care is, indeed, an improvement over existing services. Enhanced federal matching funds made available through this demonstration for services delivered to Medicaid beneficiaries offer states the opportunity to expand access to care and improve the quality of behavioral health services. CCBHC-Criteria-Updated-May-2016 (samhsa.gov)

Culturally and linguistically competent care: Culture is defined as learned patterns of thoughts and behavior, which makes particular social group distinguish from others. Cultural competency in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including the tailoring of health care delivery to meet patients' social, cultural, and linguistic needs. A culturally competent health care system is one that acknowledges the importance of culture, incorporates the assessment of cross-cultural relations, recognizes the potential impact of cultural differences, expands cultural knowledge, and adapts services to meet culturally unique needs. Ultimately, cultural competency is recognized as an essential means of reducing racial and ethnic disparities in health care. (American Hospital Association. See also: CDC's National Prevention Information Network).[iv]

Family Care Community Partnership (FCCP): FCCP serves families with children under age 18 (up to 21 in certain cases) with behavior issues, juvenile delinquency or other problems that place them at risk of involvement with the Rhode Island Department of Children, Youth and Families (DCYF). (Family Care Community Partnership (FCCP) | Family Service of RI (familyserviceri.org)

Health Equity Zone: Rhode Island's Health Equity Zone initiative is an innovative, place-based approach that brings communities together to build the infrastructure needed to achieve healthy, systemic changes at the local level. Health Equity Zones are geographic areas where existing opportunities emerge and investments are made to address differences in health outcomes. Through a collaborative, community-led process, each Health Equity Zone conducts a needs assessment and implements a data-driven plan of action to address the unique social, economic, and environmental factors that are preventing people from being as healthy as possible. HealthEquityZones.pdf (ri.gov)

Implicit bias: A form of bias that occurs automatically and unintentionally, that nevertheless affects judgments, decisions, and behaviors. Research has shown implicit bias can pose a barrier to recruiting and retaining a diverse scientific workforce. Implicit Bias | SWD at NIH

Learning, Equity & Accelerated Pathways (LEAP): A Task Force convened and engaged in a participatory, evidence-informed, data-driven process to understand impact on Rhode Island student learning in partnership with educational experts, practitioners, families, students and community members across the State of Rhode Island. A cross-departmental team at the RI Department of Education worked to support the Task Force and will oversee the implementation of its recommendations. Additionally, national researchers with expertise in various aspects of accelerated learning recovery were invited to the Task Force meetings to share evidence and support discussions. Rhode Island Department of Education > Inside RIDE > Additional Information > LEAP Task Force

Mobile Response and Stabilization Services (MRSS): MRSS provide mobile, on-site and rapid intervention for youth experiencing a behavioral health crisis, allowing for immediate de-escalation of the situation in the least restrictive setting possible; prevention of the condition from worsening; and the timely stabilization of the crisis. The mobile crisis component of MRSS is designed to provide time-limited, on-demand crisis intervention services in any setting in which a behavioral health crisis is occurring, including homes, schools and EDs. Depending on the needs of the child, the stabilization component may include a temporary, out-of-home crisis resolution in a safe environment. Mobile-Crisis-Response-&-Stabilization-Services-May-2016.pdf (umaryland.edu)

Multi-Tier System of Supports: Multi-Tier System of Supports is a framework for school improvement to ensure that all students, including general education, multi-lingual learners, and students with Individualized Education Programs (IEPs), are supported to help them meet academic, behavioral, and social-emotional outcomes.

Patient Centered Medical Home (PCMH) Kids: PCMH-Kids is a multi-payer, primary care payment and delivery system reform initiative that was convened in 2013 to extend the transformation of primary care to practices that serve children across Rhode Island. What is PCMH-Kids? | CTC-RI

Person-centered Care: "In [person]-centered care, an individual's specific health needs and desired health outcomes are the driving force behind all health care decisions and quality measurements. [People] are partners with their health care providers, and providers treat [people] not only from a clinical perspective, but also from an emotional, mental, spiritual, social, and financial perspective." (New England Journal of Medicine Catalyst, January 2017)

Project AWARE (Advancing Wellness and Resiliency in Education): This program helps build or expand state and local governments' coordination to increase awareness of mental health issues among school-aged youths. It also provides training for school personnel and other adults who interact with school-aged youths to detect and respond to mental health issues, and connect to services school-aged youths who may have behavioral health issues – including serious emotional disturbance (SED) or serious mental illness (SMI) – and their families. Project AWARE | SAMHSA

Protective factors: A characteristic at the biological, psychological, family, or community (including peers and culture) level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes.[v]

Race: A socially constructed system of categorizing humans largely based on observable physical features (phenotypes), such as skin color, and on ancestry. There is no scientific basis for or discernible distinction between racial categories. The ideology of race has become embedded in our identities, institutions and culture and is used as a basis for discrimination and domination. (Annie E. Casey Foundation, Racial Justice Definitions)

Race equity: The state, quality or ideal of being just, impartial, and fair [on the basis of race]. The concept of equity is synonymous with fairness and justice. It is helpful to think of equity as not simply a desired state of affairs or a lofty value. To achieve and sustain equity, it needs to be thought of as a structural and systemic concept.

Equity involves trying to understand and give people what they need to enjoy full, healthy lives. Equality, in contrast, aims to ensure that everyone gets the same things in order to enjoy full, healthy lives. Like equity, equality aims to promote fairness and justice, but it can only work if everyone starts from the same place and needs the same things. (Annie E. Casey Foundation, Racial Justice Definitions)

Rhode Island Children's Information System (RICHIST): The RI Department of Children, Youth and Family's (DCYF) automated information system to record DCYF work on behalf of DCYF clients and the state. It is the required method of documenting the Department's work. RICHIST includes information relating to:

- Individuals and families (service management),
- Client services (provider management),
- Finances (financial management) and
- Staff (staff management).

Rhode Island Department of Children, Youth and Families, Policy: 700.0100

Rhode Island Family Information System (RIFIS): A web-based application providing tools for case management, service coordination and reporting that has been configured to automate the requirements and instruments defined by the RI Department of Children, Youth and Families. Rhode Island Family Information System (RIFIS) | RI Department of Children, Youth & Families

Rhode Island Regional Prevention Coalitions: The Rhode Island Regional Coalitions are a group of dedicated members and partners working together to provide substance use prevention strategies, mental health resources, and advocate for policies that support healthy and safe communities. Rhode Island Regional Prevention Coalitions (riprevention.org)

Siloed funding: Government funding today is often siloed. Individual agencies and governments tend to focus solely on their specific mandate and budget. This leads to the "wrong pockets problem"; simply put, if an agency or a government is expected to bear the cost of a program, but

does not see the benefit in their budget, there is little incentive to implement. Government's Big Problem and How to Fix It | HuffPost Impact

Social Determinants of Health: Conditions in the places where people live, learn, work, and play that affect **a** wide range of health and quality-of life-risks and outcome. The CDC includes five main determinants: Healthcare access and quality; education access and quality; social and community context; economic stability; neighborhood and built environment (Centers for Disease Control)

Structural racism: The racial bias across institutions and society. It describes the cumulative and compounding effects of an array of factors that systematically privilege white people and disadvantage people of color.

Since the word "racism" often is understood as a conscious belief, "racialization" may be a better way to describe a process that does not require intentionality. Race equity expert John A. Powell writes: "'Racialization' connotes a process rather than a static event. It underscores the fluid and dynamic nature of race… 'Structural racialization' is a set of processes that may generate disparities or depress life outcomes without any racist actors." (Annie E. Casey Foundation, Racial Justice Definitions)

Trauma-informed: Trauma-informed care recognizes and responds to the signs, symptoms, and risks of trauma to better support the health needs of patients who have experienced Adverse Childhood Experiences (ACEs) and toxic stress.[vi] Trauma-informed care is a framework that involves[vii]:

- **Understanding the prevalence of trauma and adversity and their impacts on health and behavior**
- **Recognizing** the effects of trauma and adversity on health and behavior
- **Training** leadership, providers, and staff on **responding** to patients with best practices in trauma-informed care
- **Integrating** knowledge about trauma and adversity into policies, procedures, practices and treatment planning, and
- **Avoiding** re-traumatization by approaching patients who have experienced ACEs and/or other adversities with non-judgmental support.

Wraparound: Wraparound is a team-based care planning approach that builds upon strengths to identify appropriate formal and informal supports to address needs and root causes of challenges.
Intensive Care Coordination for Children and Youth with Complex Mental and Substance Use Disorders State and Community Profiles (samhsa.gov)
About – Rhode Island Regional Prevention Coalitions (riprevention.org)

Problem Diagnosis

Current Behavioral Health Status of Rhode Island Children and Youth and of the Existing System of Care, from the Rhode Island Behavioral Health System Review

Families, providers, and policymakers are sharing a deep and growing concern about the challenges facing our Rhode Island youth.

As noted above, there are four major components of the current behavioral health crisis that we include in our Problem Diagnosis:

- **Population level challenges** – including structural racism and the inequities of the ability of all Rhode Island families to access appropriate Social Determinants of Health.
- **Mental health and substance use conditions** affecting children, youth, and families that are rising in scope and severity over the past number of years.
- **COVID**, which has had an enormous impact on our Rhode Island families and their children, of isolation, school closures, economic challenges, and grief and loss
- **The inadequacy of the Rhode Island behavioral health system** – which, underfunded for years, has led to workforce shortages, siloed state agency approaches and policies, and waiting lists that leave families at risk.

Population Level Challenges

We begin with an exploration of the impact of structural racism on behavioral health, and a review of the social determinants of health that have the largest impact on behavioral health including housing and economic challenges.

Structural Racism: Because of structural racism, we know children and youth of color access behavioral health services at a lower rate than their white counterparts. Yet, we also know that the behavioral health needs for children and youth of color may actually be *higher*, more likely to be undetected, dismissed, and undertreated[viii].

> "Many of identifiable risk factors for mental illness disproportionately affect minority children, such as poverty, food insecurity, and exposure to violence… racism…maternal depression…and compound community violence" (Margarita, 2010).

In addition, the need for services is more likely to be dismissed or mistreated: Many youth with mental disorders are typically referred to juvenile justice if they display of aggressive or disruptive behaviors, without consideration of whether these are untreated mental health problems. There has also been increasing recognition that children in the child welfare system have extremely high mental health needs, 30 with prevalence rates estimated at close to 50 percent. However, they are significantly underserved with respect to mental health services, partly due to a shortage of mental health providers to address their needs (Margarita, 2010).

An article in the journal of the American Academy of Pediatrics, *The Impact of Racism on Child and Adolescent Health*, explains why racism is a both a physical and mental health crisis: "The impact of racism has been linked to birth disparities and mental health problems in children and adolescents. The biological mechanism that emerges from chronic stress leads to increased and prolonged levels of exposure to stress hormones and oxidative stress at the cellular level. Prolonged exposure to stress hormones, such as cortisol, leads to inflammatory reactions that predispose individuals to chronic disease. As an example, racial disparities in the infant mortality rate remain and the complications of low birth weight have been associated with perceived racial discrimination and maternal stress" (Trent, 2019).[ix]

The author underlines why it is critical that this System of Care plan and implementation is carried out with a race equity lens: "Although progress has been made toward racial equality and equity,9 the evidence to support the continued negative impact of racism on health and well-being through implicit and explicit biases, institutional structures, and interpersonal relationships is clear. Failure to address racism will continue to undermine health equity for all children, adolescents, emerging adults, and their families" (Trent, 2019).

Housing:

In an article on the Urban Institute's Housing Matters Initiative, researcher Will Schupmann notes:

> *"Using data on children ranging widely in age, a team of child development researchers found that children from low-income households living in concentrated poverty were more developmentally harmed by poor housing quality than by residential instability, unaffordability, or other housing factors. Children who lived with leaking roofs, exposed wires, pest infestation, and other problems were more likely to exhibit emotional and behavioral problems, which manifested themselves through anxiety, depression, and other internalizations in some children, and more outwardly aggressive behaviors and rule breaking in others. By adolescence, poor-quality housing was associated with lower reading and math scores on standardized tests."*[x]

The state of housing stock for families in Rhode Island is a particular worry, then, as only 6% of homes built before 1979, making up 74% of housing in the state, are certified Lead Safe. Additionally, as much as 40% of asthma triggers are attributed to fixable hazards within homes and Rhode Island children experience one of the highest rates of asthma in the country at 8%. These rates disproportionately impact low-income neighborhoods and Black and Latino children in the state.

In addition, Rhode Island has seen a four-fold increase in street homelessness since the 2019 Point in Time Count. The COVID-19 pandemic has heighted the awareness of homelessness as a public health issue and the state's shelter system, already at capacity, was mandated to reduce beds by 146. Consequently, there are approximately 500 individuals and families living in a hotel through a state-funded program that was slated to end September 30, 2021 or sleeping in reconfigured

places not originally meant for human habitation. Communities of color in Rhode Island experience homelessness at rates exceeding their proportion of the state's population.

The State has committed to addressing street homelessness through the creation of permanent supportive housing and initiatives in the budget passed in June 2021 by the Rhode Island General Assembly, but we know that there are additional stressors for families who are affected by housing insecurity – especially with the lifting of the COVID-related eviction moratorium. Families may not be living on the street, but may need to move frequently, when rents are raised, necessitating a change in school districts for children. A residential move is associated with the educational loss of nearly half an academic year as stable living conditions reduce barriers to academic success like chronic absenteeism.

Significant Economic Challenges:
Disparities in earnings for women compared to men persist, especially impacting women of color. The childcare and caregiving industries are primarily made up of women, and the majority of these positions pay wages that are barely above the Federal Poverty Line and less than half of the actual cost for parents to raise a toddler and school age child in Rhode Island[xi].

The Child Care Assistance Program (CCAP), operated through the Rhode Island Department of Human Services, assists low-income families in the state that qualify at 180% below the Federal Poverty Level. With average childcare costs exceeding $10,000 annually, this income level qualification creates a gap for many families that do not meet that requirement but are still in need of assistance[xii].

As of September 1, 2021, The Rhode Island Works program assistance increased for the first time in decades – a significant step towards reducing poverty rates among children and families. However, even with this 30% increase, the new monthly assistance amounts do not meet today's inflation rate – making it extremely difficult for low-income families to survive without adequate education or employment.

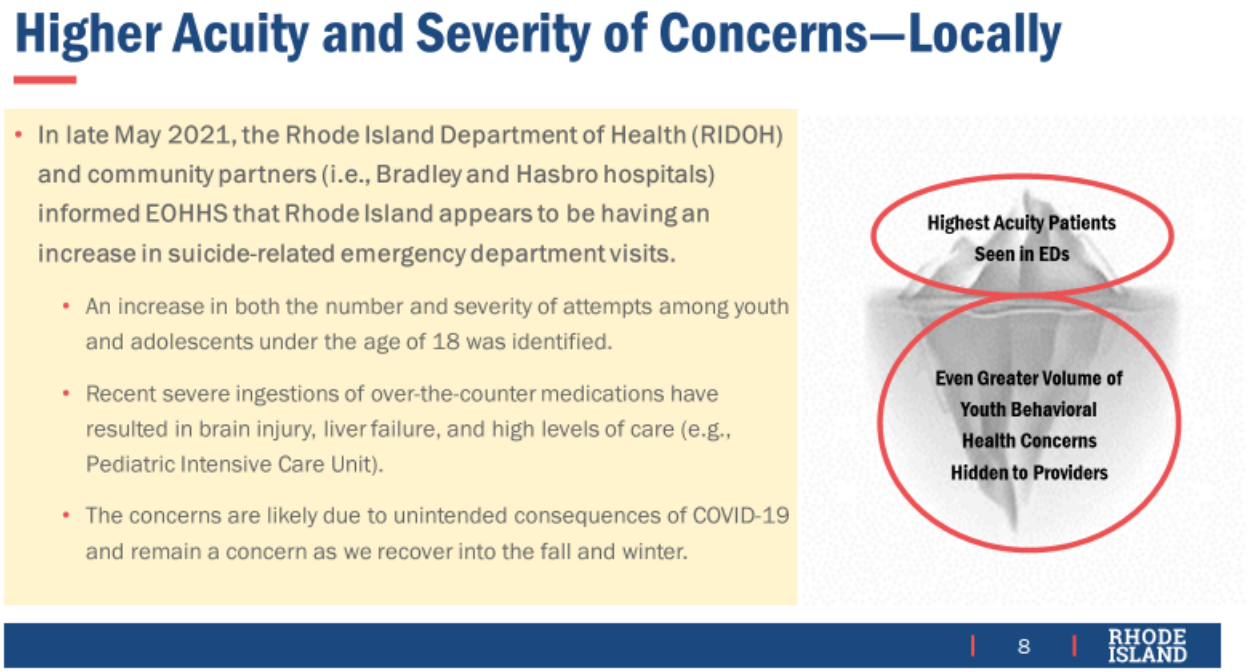
Because Rhode Island still has much to do to address family poverty, we see the impact on our behavioral health system. In an article in Psychiatric Times, Dr. Kevin Simon notes, "Individuals who experience poverty, particularly early in life or for an extended period, are at risk of a host of adverse health and developmental outcomes through their life. Poverty in childhood is associated with lower school achievement; worse cognitive, behavioral, and attention-related outcomes; higher rates of delinquency, depressive and anxiety disorders; and higher rates of almost every psychiatric disorder in adulthood. Poverty in adulthood is linked to depressive disorders, anxiety disorders, psychological distress, and suicide" (Simon).

Quantitative Data: Behavioral Health and Substance Use Conditions Affecting Children, Youth, and Families, with a focus on the COVID Time Period

Moving to the problems specific to children, youth, and families at the heart of this plan, the System of Care Data Planning Team led by EOHHS reviewed quantitative data on children and youth in crisis, focusing in on metrics such as suicide attempts, anxiety, and depression, and eating disorders, by gender and race and ethnicity. The data show that crisis predated, and worsened significantly throughout, the COVID pandemic.

This slide shows the severity of the concern and that we are only looking at the tip of the iceberg of our youth's needs. It is important that we look at the differences in the needs by gender, race, and ethnicity, and throughout this plan – when the data exist – we show those differences and consider their meaning.

Figure 1: Local Acuity of Behavioral Health Concerns



To put this in context with the national scenario, behavioral health concerns were rising throughout the country before COVID, but the pandemic worsened things in all states:

Figure 2 and 3: National Behavioral Health Concerns & Rhode Island Responses

Rising Youth Behavioral Health Concerns—Nationally

- According to the National Institute for Health Care Management, there has been a 74% increase in depression for children ages 12-17 when comparing 2004 and 2019 data:
  - Adolescent girls are over 2x as likely to have an episode of major depression
  - Mental health emergency department visits increased 24% for children ages 5-11 and 31% for adolescents ages 12-17 between mid-March and October 2020 compared to the same time period during 2019
- The Centers for Disease Control and Prevention released a *Morbidity and Mortality Weekly Report* on June 11 that confirmed an increase in emergency visits for suspected suicide attempts among youth.
  - By May 2020, Emergency Department visits for suspected suicide attempts began increasing among adolescents aged 12-17 years—particularly among females.
  - The weekly mean number of these visits in this population of females from February through March 2021 was 50.6% higher than during the same period a year earlier.
  - Further, the proportional of mental health-related emergency visits among adolescents aged 12-17 years increased 31% in 2020 compared to the same time period in 2019.

6 | RHODE ISLAND

When the EOHHS team showed the data to our partners in the provider community, especially to pediatricians and parents, they concurred. The issues are immensely troubling to Rhode Island behavioral health experts, and they are pushing the state to respond.

Provider and Partner Concerns from the Field

Our partners, including the Pediatric Advisory Council, psychiatric hospitals, Primary Care Physician Advisory Committee, Regional Prevention Coalition event attendees, and Child Wellbeing Group have noted the following concerns related to youth behavioral health as we recovery from the pandemic:

- "...the severity of suicide attempts appear to be increasing, with ingestions leading to liver damage and brain injury in youth."
- "...youth behavioral health needs are what is driving increases in many of our pediatric office visits."
- "...youth anxiety, depression, social isolation, disengagement, and poor sleep remain as specific issues identified recently with our pediatric patient visits."
- "...concerned about social media addiction, lack of mealtime structure, parental distress, significant weight gain, eating disorders, and use of THC/hallucinogens in our youth."

RHODE ISLAND

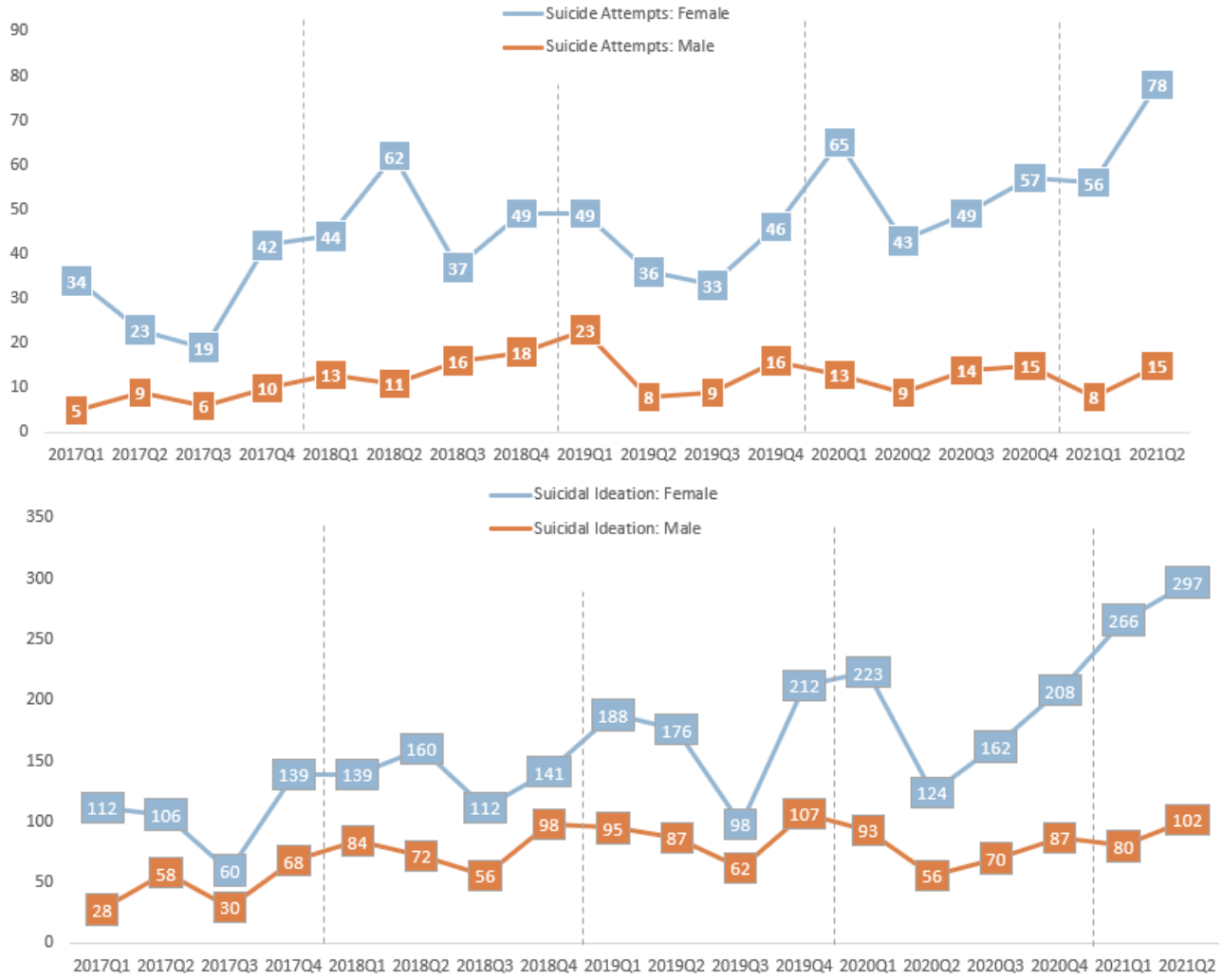
Detailed Quantitative Analysis Findings

Rhode Island is a national leader in youth suicide prevention and has one of the lowest rates of completed suicides from children under 18 in the country. However, in the **three years from 2018-2020, there were 18 completed suicides** among 15- to 24-year-olds in Rhode Island – an average of six per year. **But in the first 8 months of 2021, there were *ten*.**

To give context to this growing crisis, the data below reflect myriad expressions of behavioral health needs, from anxiety and depression through suicidal ideation and attempts, across all kids, and then for specific groups (by gender; for just Medicaid; by race and ethnicity).

Using statewide hospital surveillance data from the Department of Health, we can see that suicide attempts (top chart) and ideation (bottom chart) are rising for girls.

Figures 4 and 5: Hospital Surveillance Data of Youth Suicide Attempts and Ideation by Gender



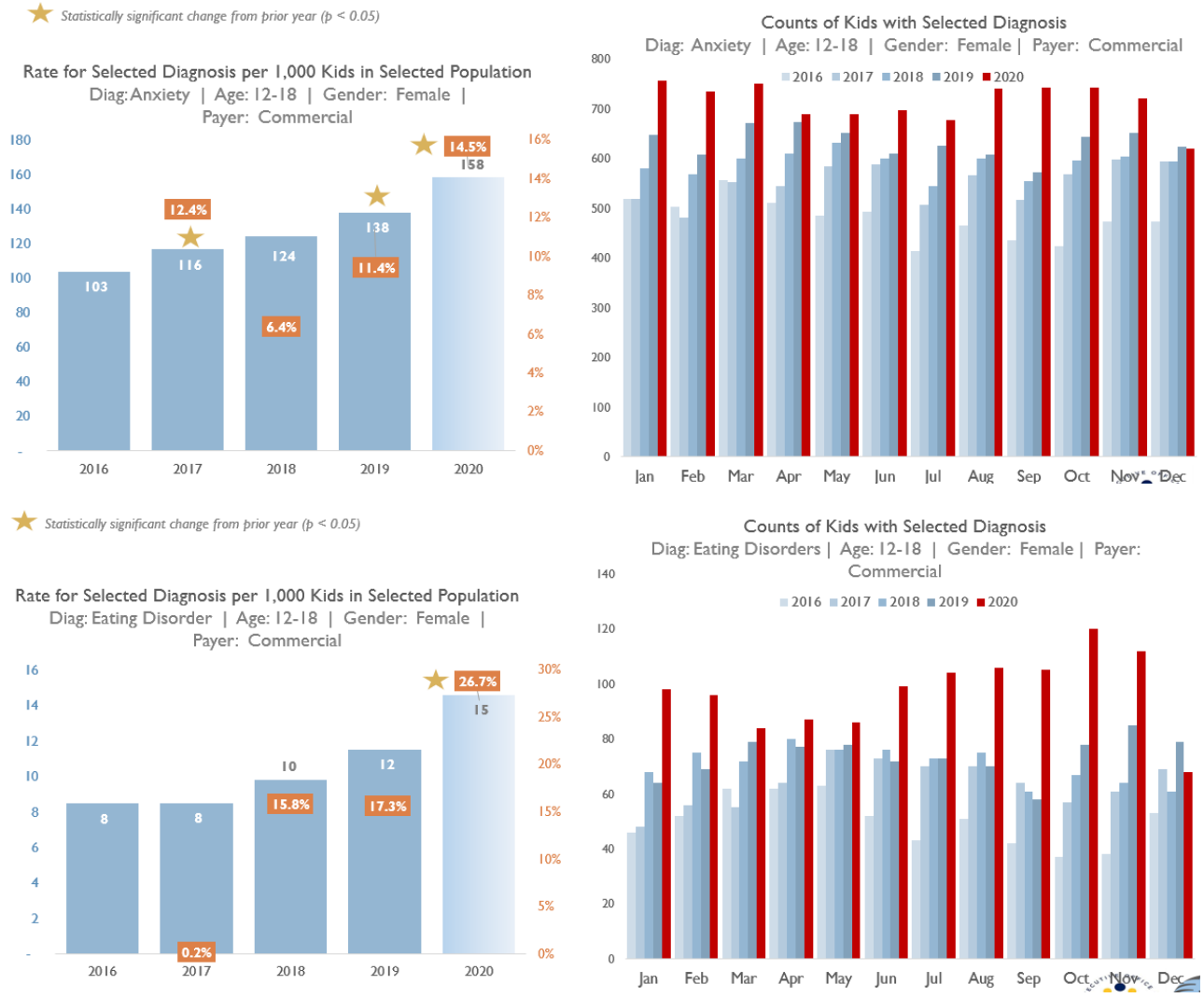
Data Source: ESSENCE hospital surveillance reporting, all payers

The above data show information on suicide attempts and ideation. Importantly, however, boys and young men are overrepresented in the most tragic outcome: completed suicides. Using regional data, we know that 78% of completed suicides among those age 15-24 in the Northeast between 2016 and 2019 were male.

Below the waterline of these most severe and tragic outcomes is the growing crisis in adolescent behavioral health needs, which pre-dated but was exacerbated by the pandemic.

Using the All Payer Claims Database (APCD), we can see that it is not just crisis-level needs that are rising: anxiety (top chart) and eating disorders (bottom chart) are growing each year for commercially insured female adolescents – and spiked in 2020 even with data pending for 2020 quarter 4.

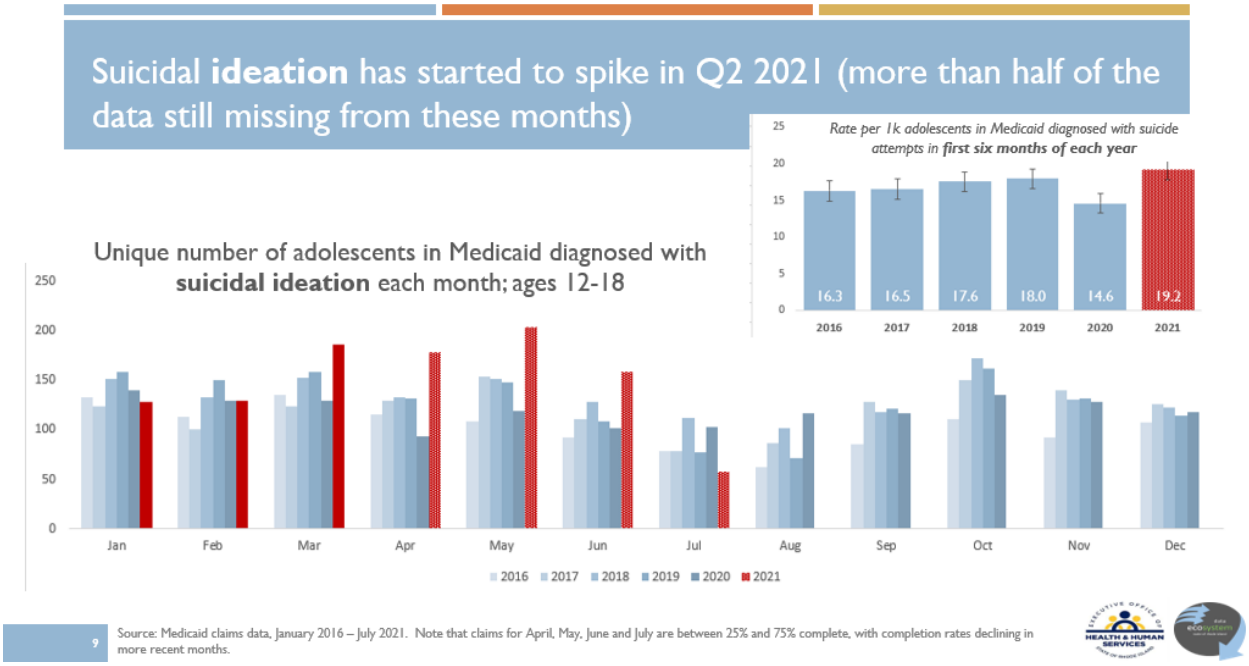
Figures 6 and 7: Youth Anxiety and Eating Disorder Diagnoses

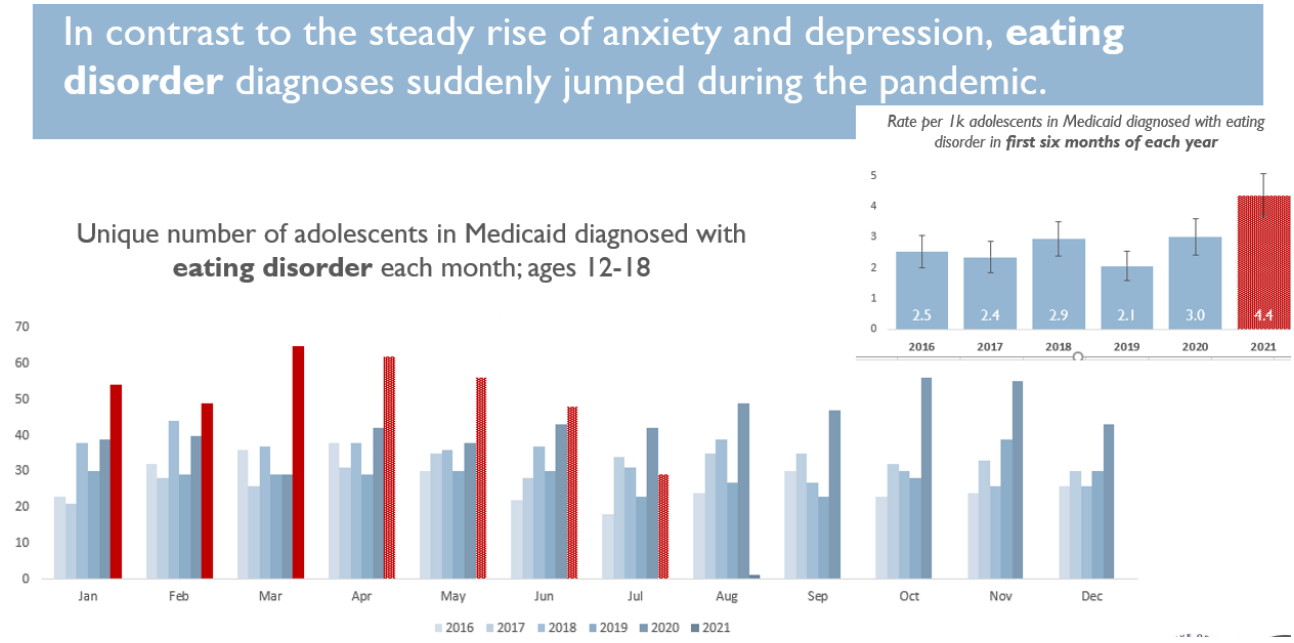


Data Source: All Payer Claims Database through Dec. 2020

In Medicaid, which has more recently available data, the behavioral health needs and service for adolescents continue, and have worsened in the first six months of 2021.

Figures 8 and 9: Increases in Youth Behavioral Health Diagnoses

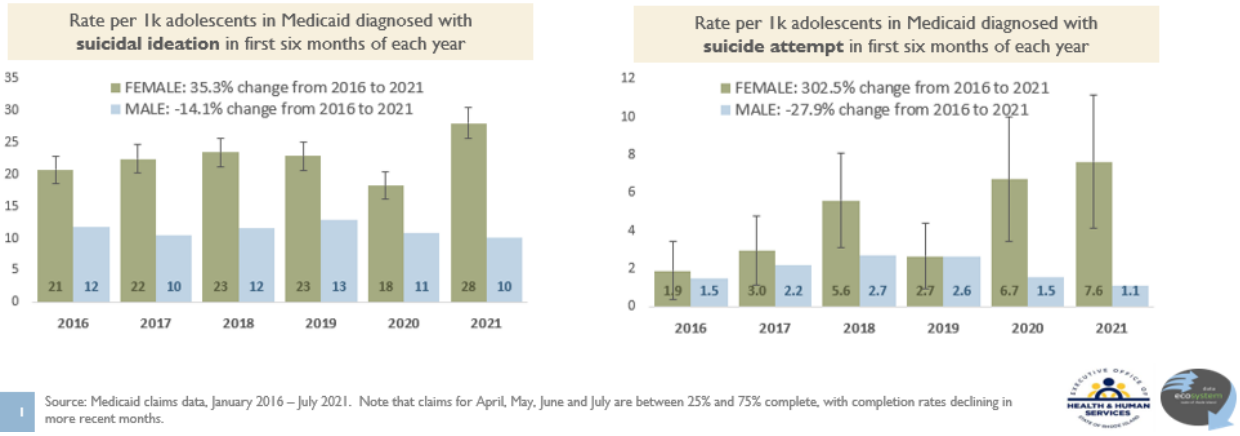




Data Source: Medicaid Claims Database through July 2021

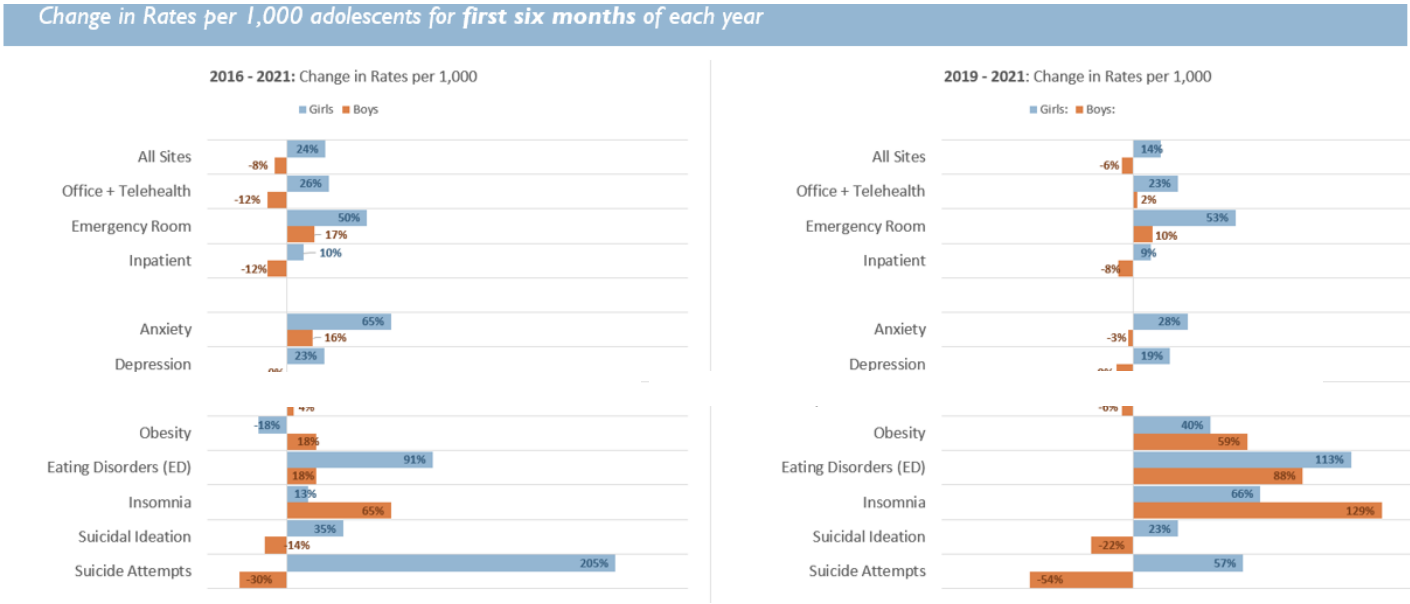
The crisis plays out differently for those identifying as boys and identifying as girls. Our data show lower use of services for behavioral health needs for boys - who may express behavioral need differently, have different cultural context for acknowledging and seeking support for the need, or who may have genuinely different prevalence. This disparity is present at the most acute levels (ideation and attempts below).

Figures 10 and 11: Medicaid Claims Data of Youth Suicide Ideation and Attempts and Behavioral Health Diagnoses



Data Source: Medicaid Claims Database through June 2021

It's also apparent across most other settings and diagnoses – except for behavioral manifestations, such as insomnia and eating disorders.

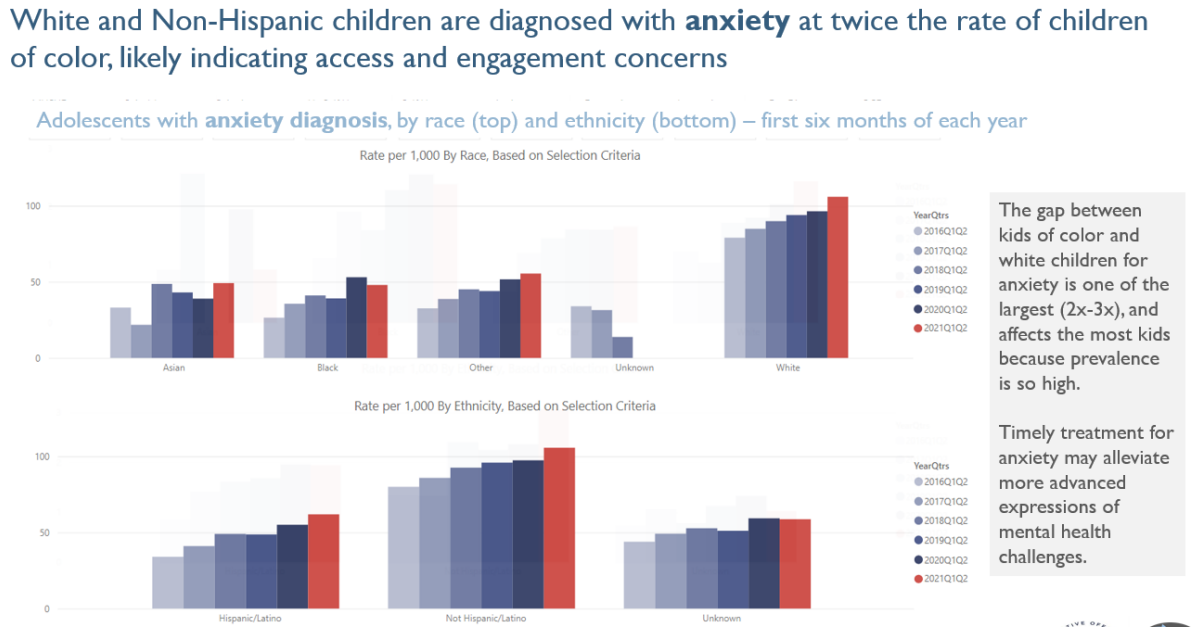


Data Source: Medicaid Claims Database through June 2021

And disparities persist by race and ethnicity, with white- and non-Hispanic-identified adolescents more likely to, and able to, access services than those who identify as Black, Asian, Hispanic, or Other. We know that lower rates of diagnosis for children of color do not represent lower need or prevalence. In fact, due to the legacy of systemic racism, the need may actually be higher. Notably, the gaps are most significant for anxiety and depression, representing the broadest range of access and services, than for emergency, crisis-level needs, such as suicide attempts.

Data Source: Medicaid Claims Database through June 2021

Figures 12 and 13: Behavioral Health Diagnoses by Race and Ethnicity



The role of schools in supporting student social, emotional, and behavioral health cannot be overstated. Research demonstrates that schools that create safe, supportive, and predicable environments support student social and emotional health as well as academic success of all students.

Summary of Quantitative Data Findings

Key diagnosis and service use trends – which may not indicate underlying prevalence or actual need - from the Ecosystem reflected in the data above and in Appendix 1 suggest the following about the state of children and youth behavioral health in Rhode Island.

- Based on claims-based diagnosis rates, Rhode Island has been in a mental health crisis for several years, and it worsened during the COVID pandemic, especially for suicidality.
- As a state, we should expect things to get worse this fall. Suicidality tends to be seasonal and peaks in August through October for children and youth. Unfortunately, as bad as things have been through 2021 so far - with spikes in March to May - we are not yet in our peak period, and COVID is still very much with us.
- Those identifying as boys and those identifying as girls experience this crisis differently: we see high rates of diagnosis and service use for girls, less so for boys - except for outward behavioral manifestations of anxiety (e.g., insomnia or eating disorders) and suicidality (ideation or completions).
    - School and clinical experts advising the data team have explained that this disparity is less of a reflection on prevalence and instead is more reflective of an environment that doesn't "see" how behavioral health concerns may manifest in boys and that holds a bias against seeking care for needs that don't manifest as aggression or problematic behaviors.
- The data show consistently higher diagnosis and service use for white, non-Hispanic children and youth - which is less a reflection of actual prevalence and instead is more reflective of the lack of culturally competent, linguistically appropriate care, and lack of access to options that fit the resources of the children and their families. In a study on the prevalence and treatment of depression, anxiety, and conduct disorders in American children, Ghandour et al. (2018) conclude that differences in the likelihood of diagnosis and treatment by race and ethnicity can be attributed to a combination of factors including access to care, greater resiliency for Black and Hispanic population due to familial closeness, and the potential for diagnostic bias. Efforts to increase access to culturally competent, linguistically appropriate care will be an ongoing focus for the System of Care.

One critical note about the information the data team reviewed is that it only focused on insurance-paid services that generate a claim and a behavioral health diagnosis. Children and young adults receive behavioral health support in many other formal and informal – specifically, school-based supports, which are a crucial system of support and intervention, are not included in these trends. But that absence also represents the gap between how kids are supported in

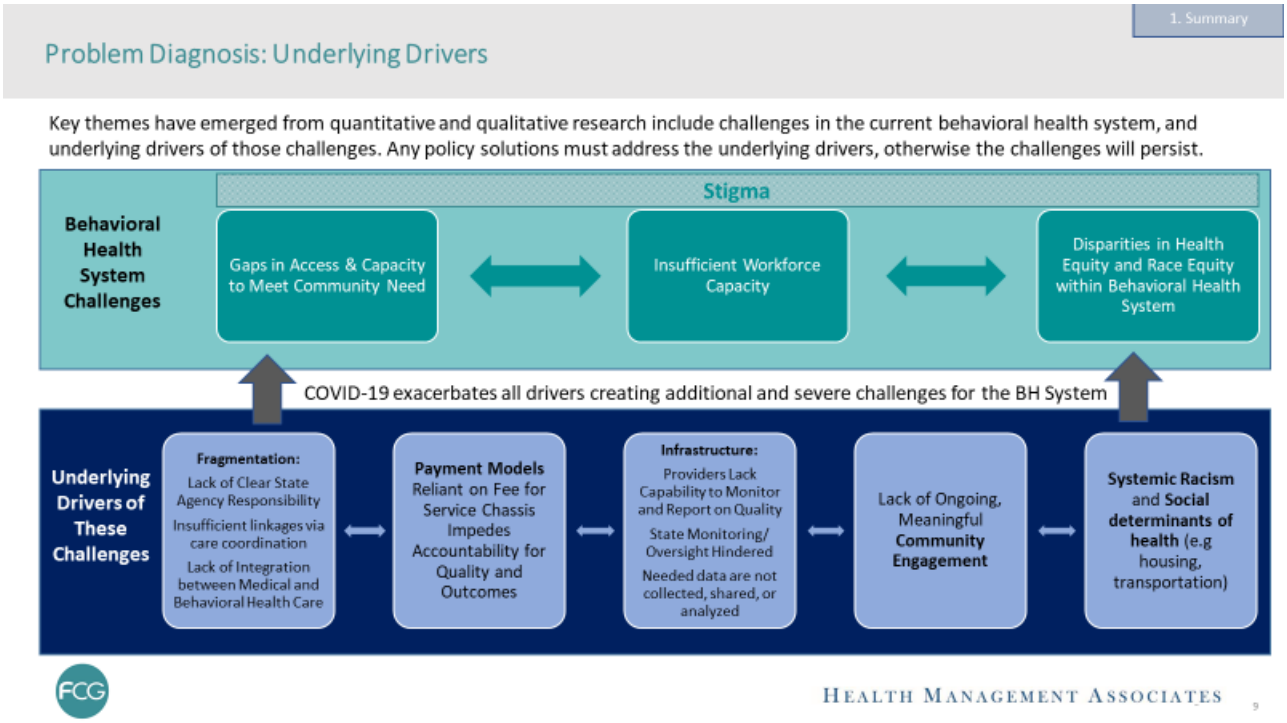
schools for holistic social, emotional, and behavioral health needs, and how they receive (or don't receive) clinical support from the medical system.

Children and Youth Behavioral Health Qualitative Community Partner Feedback

Thanks to funding from the Centers for Medicare and Medicaid Services as a result of the SUPPORT Act, in 2021, the Executive Office of Health and Human Services contracted for a comprehensive Behavioral Health System Review. The review was carried out by the Faulkner Consulting Group and Health Management Associates, with significant community partner engagement.

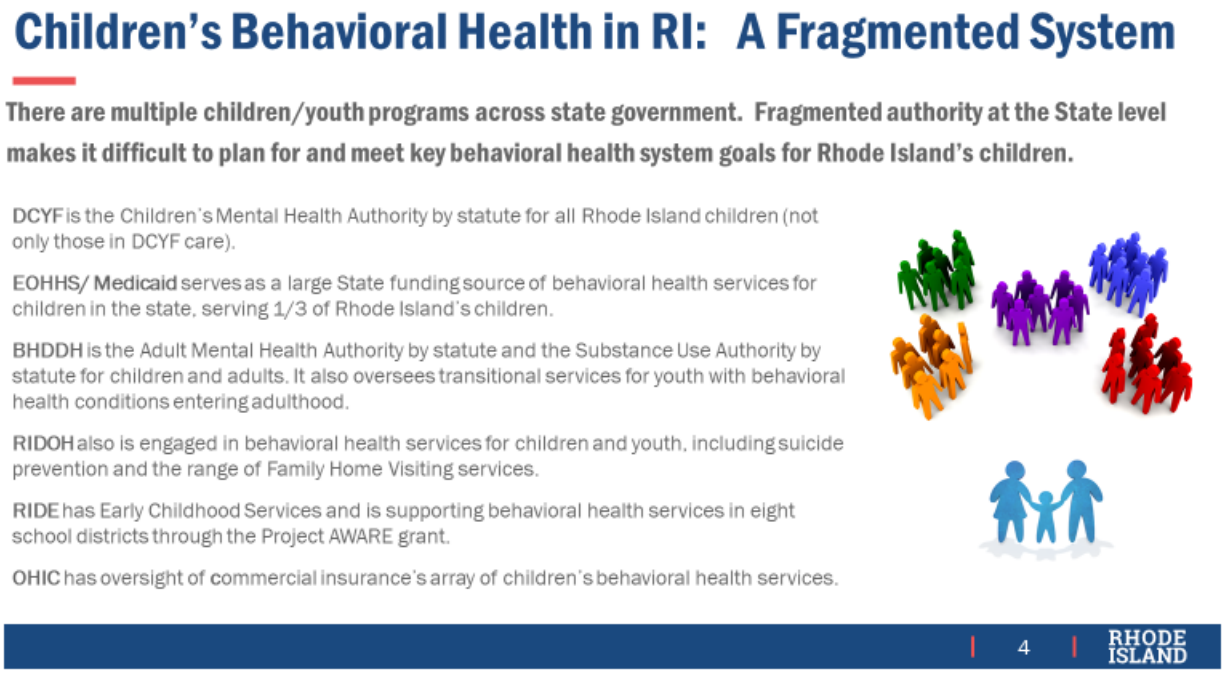
The review identified both a set of principles that partners identified for our overarching behavioral health system, as well as the challenges faced by the system and their underlying drivers.

Figure 14: *Rhode Island Behavioral Health System Review 2021* Problem Diagnosis



From the beginning of the planning process, the state planning team laid out the systemic challenges present in state government that lead to silos in our children's behavioral health system as presented in the Figure below.

Figure 15: Current System Fragmentation



Besides the quantitative data analysis that painted an alarming picture of Rhode Island's behavioral health needs for children, youth, and young adults, EOHHS also sought community partner participation in creating this problem diagnosis, with an initial public meeting on April 8, 2021 and the development of eight Work Groups that explored the following issues.

Community partners acknowledged the high quality of certain providers in the state, while also underlining the challenges and problems in our system of care. Community partners describe a system that is fractured – and that does not meet the high expectations that the state, our provider community, and most importantly our children, youth, and families have for the system that Rhode Island needs.

The challenges begin with the lack of prevention of behavioral health crises. Then, families experiencing behavioral health crises face a system that is daunting and sometimes impossible to navigate: when a child experiences a behavioral health crisis, especially for the first time, parents may not know what to do, or know which providers or what services are available to help meet their child's and family's needs. Children are forced to remain in inadequate, temporary settings either because there are no beds in children's psychiatric hospitals (when they need higher level care) or there are no slots in more appropriate intensive home and community-based services.

Community Partner Commentary

Here is a representative sampling of community partner feedback about a range of system components and the challenges they see.

System is too siloed: Many of the community partners described a system that is not One reason for these challenges is that our current system is siloed, with responsibility for children's behavioral health services fragmented across different state agencies and too often carried out in more restrictive programs than necessary. Per Rhode Island General Law, the Department of Children, Youth & Families (DCYF) is responsible for planning, developing, and evaluating a comprehensive and integrated statewide array of appropriate behavioral health services for children – but several other state agencies have responsibility for pieces of the children's system of care, including the Departments of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), Elementary and Secondary Education (RIDE), Health (RIDOH), and RI Medicaid.

This makes it difficult for the system to deliver effective behavioral healthcare to all of our children and families in Rhode Island. And for children and families of color, structural racism makes the challenges getting appropriate services to meet their needs even more difficult.

Community partners explain the problems these silos lead to for families, including the need to "better align people with the services they need."

Throughout the planning process, there were numerous discussions about how to connect the care system with the schools: "Schools have their own behavioral health systems and procedures that are sometimes separate and self-contained from the non-school behavioral healthcare system."

There were also many discussions about connecting with pediatricians and their offices. Pediatricians note that their offices are well-placed to be the anchor for care coordination for children with behavioral health needs.

Finally, another community partner noted: "The system in Rhode Island is not working. Elements may be helpful to families but not the system as a whole. Families and kids get partially what they need. We're not 100% confident we're doing what we can and should be doing."

Rhode Island has a Workforce Crisis, affecting Capacity and Access:
Overall, the most concerning issues for community partners are workforce shortages. These predate the COVID-19 pandemic and have only grown more acute since its onset. Systems related gaps include shortages in key areas of behavioral health providers, including psychiatrists, mid-level practitioners, and the entry level workforce. There are widespread, high levels of turnover or position vacancies among the network of behavioral healthcare provider across the lifespan – due to significant concern about compensation and burnout.

Specifically, immigrants and people of color (particularly Latinx Rhode Islanders) are significantly under-represented among clinicians, which diminishes capacity to provide culturally and linguistically competent care.

The needs of transition-age youth (those who are between 16 and 26) are also daunting because the children's and adult systems are currently separate and there, and families have difficulty moving between them. There are also different eligibility, coverage and definitions for childhood and adult behavioral health, issues and young adults are often treated along with older adults in settings and groups that are not conducive to their treatment and recovery.

In a meeting of the Crisis Continuum Work Group on August 4, a community partner emphasized: "We need to establish a sufficient workforce, or this is just going to fall apart. Need to focus on rates and wages first. Last thing we want is have families referred to a waitlist."

During the April 8 meeting, one community partner emphasized the importance of "having 1) reimbursement rates that support a quality and diverse workforce- we cannot have a robust system of care if we lose all of our clinicians to Massachusetts and Connecticut, 2) a trauma-informed approach and training in evidence-based treatments 3) Increased participation in the design of a System of Care from families and youth 4) Intensive community-based treatment services for families who are not involved with DCYF, and 5) a centralized data system that is accessible to providers and families (with families consenting and understanding the data collection process)."

Another community partner on April 8 was clear: "From provider's perspective, the level of commitment from the state so far has not been good. Our workforce crisis is unprecedented, and without them the system would fail. More support is very much needed."

In a meeting of the Workforce Work Group on May 6, another community partner stated the following:

1) Reintegrate intensive community-based services, in a home-based way. … When we've had these services, they had been integrated with school systems, to work with schools to stabilize kids. From my point of view, this is something that could be done relative quickly, in terms of going to MCOs and undoing some of the things they've done called enhanced out-patient services. We don't have that foundation as the state. One of the things we see for kids being boarded in Eds. Kid not being able to be transitioned out of hospital programs.

2) We effectively don't have mobile crisis services. While we do have BH Link for adults, we need to reinstate this mobile services and crisis system with 24/7 care for kids.

3) We need sustainable rates for sustainable services - connected to some level of case management, especially for high stress communities – Providence, Woonsocket, Central Falls, and Warwick. For places with a high level of issues of social determinants of health, we especially need these case management services.

4) We need pathways to support behavioral health service providers to work in schools along with an infrastructure that support access to community-based services.

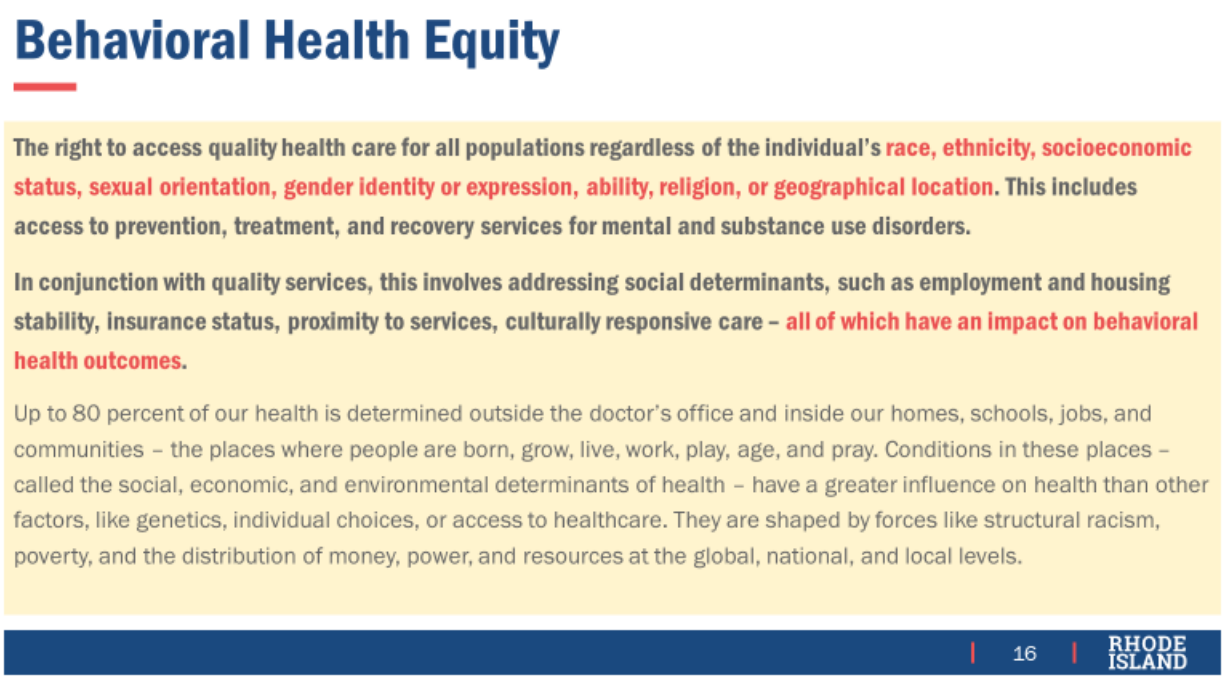
Mobile Crisis is of particular concern. Our current system has no statewide children's interventions to immediately deescalate and ameliorate crises before more restrictive interventions become necessary. One parent at the May 6 meeting shared: "This week, my 10-year-old ended up in an ambulance to the hospital. There were 30 children waiting for psych bed at Hasbro Children's Hospital, as well as multiple medical patients. Kids are put in the tiny room with no parents allowed in the room.

"I also liken this to cancer – thank God my kids don't have cancer, but they have behavioral health needs. When you have cancer, the doctors don't say you're good enough for now and stop services. This approach with mental health leaves a lot of kids dangling in the wind. It's making parents need mental health services as well because it's burning us out."

The workforce challenges have a challenging impact on the available service array for families: One community partner stated, "In terms of the service array, the thing that strikes me is the lack of intensive of clinical service in the home that are provided. Even with HBTS, PASS and others, there's not a model of intensive family therapy – family dynamics, sibling dynamics. None of the services in RI allow for that. It feels like a band-aid instead of sustainable change."

Need to Ensure Equity: The Ensuring Equity Work Group began to meet on May 20, 2021. In that discussion, facilitator James Rajotte from EOHHS laid out this ground rule for their work and shared the slide below. He stated, "I challenge all of us in the Work Group to think about our words. When we say "to be treated the same" – that's equality, not equity. We need to make sure individuals have access to the services they need and deserve, not just the exact same type of services others get. For example, maybe someone needs a 3-hour appointment, not a half hour, or maybe they need transportation and other supports in addition to their treatment. Let's hold ourselves accountable to changing the narrative."

Figure 16: Describing Behavioral Health Equity



One community partner clearly stated, "The behavioral health continuum in Rhode Island is set up to address people who are of the white majority."

Another Work Group participant noted the importance of addressing the needs of youth with intellectual disabilities: We should focus on youth transitioning from school into adult services, who have a difficult time accessing services for adolescents and young adults. We need more providers who are skilled in both intellectual and developmental disabilities and mental illness. How do we find them? And some providers have more of a medical model, and some have more of a human service model – how do we get at both for youth with intellectual disabilities?"

An Emergency Department physician spoke at the May 20th Ensuring Equity meeting shared her perspective on a key problem: "My lens is as an ED physician. It's a lack of a diverse provider population that come from diverse cultures. When assessing someone for a treatment plan, we need to consider needs of the whole family, and align with culture. We need changes in attitude based on what a patient or family needs – a global approach."

And another Work Group participant underlined the importance of reaching people where they are: "We're missing entire populations of color. They're not approached for surveys, so we're not getting their perspectives. My family (who is biracial) barely go to primary care physicians. That is not a relevant entry point to engage communities of color. If you're not going to certain places, you're not going to get services or referrals." In response, another participant noted, "The outreach team needs to go to houses, not just providers."

Urgent Need for Prevention Services:
Regarding prevention, community partners were clear that Rhode Island needs to significantly increase the options available to families:

- "There is a lack of parenting education. Part of the prevention array should be parental education and support meetings."
- "Explore the National Family Support Network which has research tied to their prevention that has data about how much they save through prevention."
- "There have been versions of resources across decades in RI. The issue is we don't take advantage of what's right in front of us in terms of how we organize them. Don't facilitate collaboration well enough. Not just how to define resources but also where they sit and how to access. Used to publish table for DCYF workers of where to get certain resources. Basic needs is badly funded – how do we fund, who funds, what organizations are used to distribute these resources. How to organize and fund consistently. No need for fancy education programs, we just want to deal with basic utility needs, kids' behavior. In essence: How to organize, where to put, how to collaborate."
- "If you see an issue a family is having how do you get them to the next resource. How to teach everyone to make referrals effectively. Worked in Mass. in DCF – brought organizations together locally to make them talk to one another around individual family situations with family in room so they can advocate for their needs."

Outreach and Education Needs: Community partners identified the need to engage families more fully, with training and resources.

- "The State needs to work to set up a system where families are informed consumers."
- "We need more resources to support families where grandparents or other family members are working as parents. Some families just need support navigating the system, others accessing basic concrete resources, others need support in understanding child development, kids who act out and are traumatized by removals (who have been kicked out) still minimal ability to support kids around guardian arrangement, foster care in general. Need more skilled clinicians across the board and need to pay them well."

Theory of Change: What Are Our System of Care Goals?

The purpose of Rhode Island's system of care expansion and sustainability planning is to build on previous alignment efforts to improve access to and services for children and youth from prevention, through crisis management, to ongoing behavioral health. The population of focus is a diverse range of children and youth, birth through age 26, with a special focus on those with, or at risk of, serious emotional disturbance (SED), first episode psychosis (FEP) or substance use disorder (SUD).

Throughout this plan, we describe the challenges we face and show that Rhode Island can accomplish the improvements we seek in our Behavioral Health System of Care for Children and Youth by decreasing fragmentation, increasing accountability, ensuring integration with physical healthcare with a focus on pediatricians' offices, and adding infrastructure that supports system organization. All steps must be grounded in a focus on racial equity, prevention, and uplifting community feedback.

Community partners throughout Rhode Island also understand the state's need to create a formal governance structure that establishes leadership, system of care principles, and clear focal points of management and accountability for the development and expansion of the system.

Therefore, our Theory of Change that we describe throughout this plan is that if Rhode Island creates an integrated, culturally and linguistically competent continuum of behavioral health care for all children in the state that begins with prevention, includes integration with primary pediatric care, and provides an organized pathway to both ongoing behavioral healthcare and crisis services and supports, families will be able to move away from the multiple, typically confusing paths they must deal with today and into a true System of Care that works for them. Then, our children and families will become healthier, more resilient, and ready to make plans for their futures, including participation in the state's education system and our economy.

Current System of Care Planning – 2018-2021

Rhode Island has a long history of working towards improving behavioral health services for children and youth, with different initiatives and programs resulting. Most recently, on May 4, 2018, Executive Order (18-03) laid out concerns and commitment to addressing Rhode Island's challenges in our behavioral health system: "Reaffirming and Expanding Rhode Island's Commitment to Persons with Mental Illness and Substance Use Disorders—Addressing Parity and Access to Timely and Needed Care." As a response to this Executive Order, the Governor's Office convened two interagency working groups—one focused on youth and the other focused on adults—tasked with proposing strategies for improving the behavioral healthcare system. The groups included experts from across the relevant state agencies (DCYF, BHDDH, RIDOH, EOHHS, Medicaid, and OHIC).

After the Executive Order, a report was issued on November 30, 2018, "Improving Behavioral Healthcare for Youth in Rhode Island," based on a set of community partner interviews from throughout the behavioral health provider community and interagency work groups. This report identified several concerns regarding Rhode Island's overall behavioral health system (reimbursement rates, behavioral health workforce concerns, etc.), and identified five specific concerns regarding children's behavioral health:

1. Limited prevention and early intervention programs are a missed opportunity for helping Rhode Island children and youth in particular.
2. Rhode Island has very few "whole family" behavioral health treatment programs.
3. Schools lack the resources to meet the behavioral health challenges presented by the youth in their care.
4. Lack of specialty care and gaps in the continuum of care pose an especially big challenge to treatment of children and youth.
5. There are very few residential substance use treatment services for youth.

In 2020, EOHHS began to plan for an updated Rhode Island Children's Behavioral Health System of Care, focusing on addressing the impact of COVID-19, our state's opioid crisis, and ongoing economic difficulties that were creating tremendous challenges for families that affect our state's children. EOHHS expanded an existing interagency team for preliminary planning, including the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, the Department of Children, Youth, and Families, the Office of the Health Insurance Commissioner, the Rhode Island Department of Education, and the Rhode Island Department of Health. Then, we engaged the statewide community to ensure extensive community partner engagement and collaboration during this process.

After individual meetings with various providers and community organizations throughout the winter of 2021, EOHHS brought the draft plan to a broad group of community members, providers,

and parents in a public meeting in April and kicked off a formal planning process with the following public/private Work Groups:

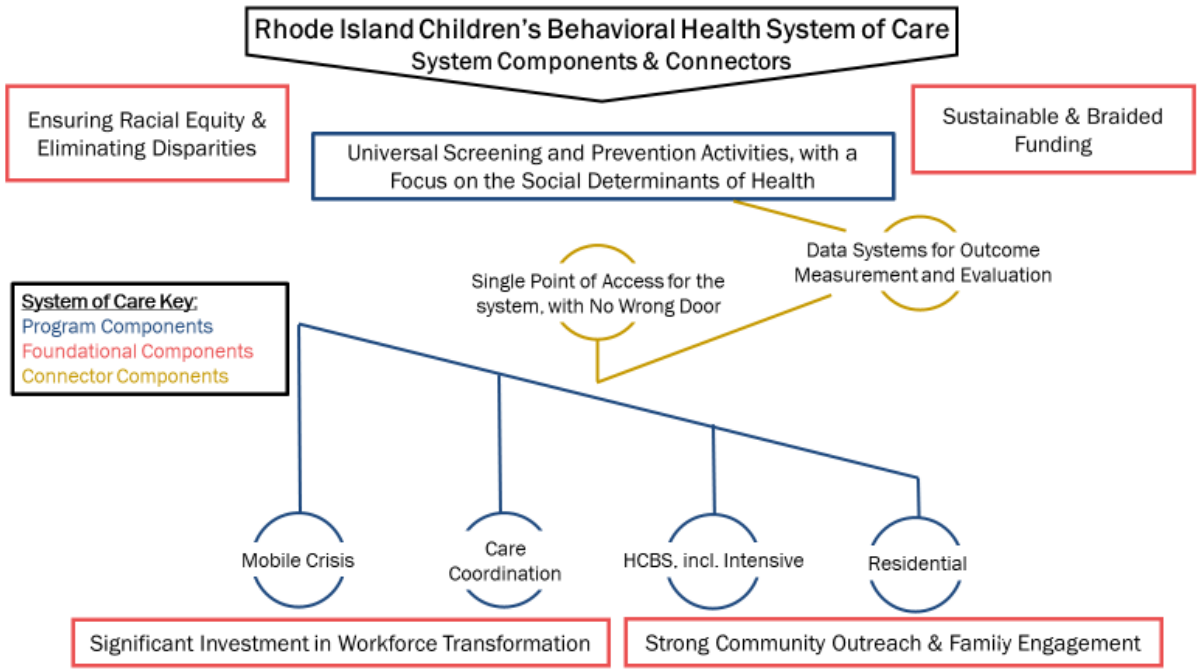
1. Crisis continuum, development and access, screening, and assessment
2. Care authorization, care coordination and care monitoring
3. Service array
4. Ensuring equity: race equity, family members, with IDD, and LGBTQ+ Families
5. Workforce transformation
6. Data systems for outcomes measurement and evaluation
7. Community outreach and education
8. Prevention (added in late June)

What is most important about our Work Group structure is that the Work Groups understand how important it is for them to work in alignment with each other. For instance, the Mobile Crisis Work Group knows that it is critical that it connect with the Workforce Work Group, to explore ways to ensure that the crisis system has enough staff to provide trauma-informed care. Each Work Group is committed to taking up the recommendations of the Ensuring Equity Work Group, because it cannot be the responsibility of the Equity Work Group alone to have the system eliminate disparities. In addition, all of the Work Group leaders and members will continue to be called upon to think through strategies to enhance the system with sustainable financing, cross-agency collaboration, creation of policy and infrastructure, and development and implementation of evidence-based and evidence-informed services.

This System of Care document is a result of the current planning process – and these Work Groups were formed to allow for broad public engagement in the specific planning for each of the components of the plan, as depicted in the visual below.

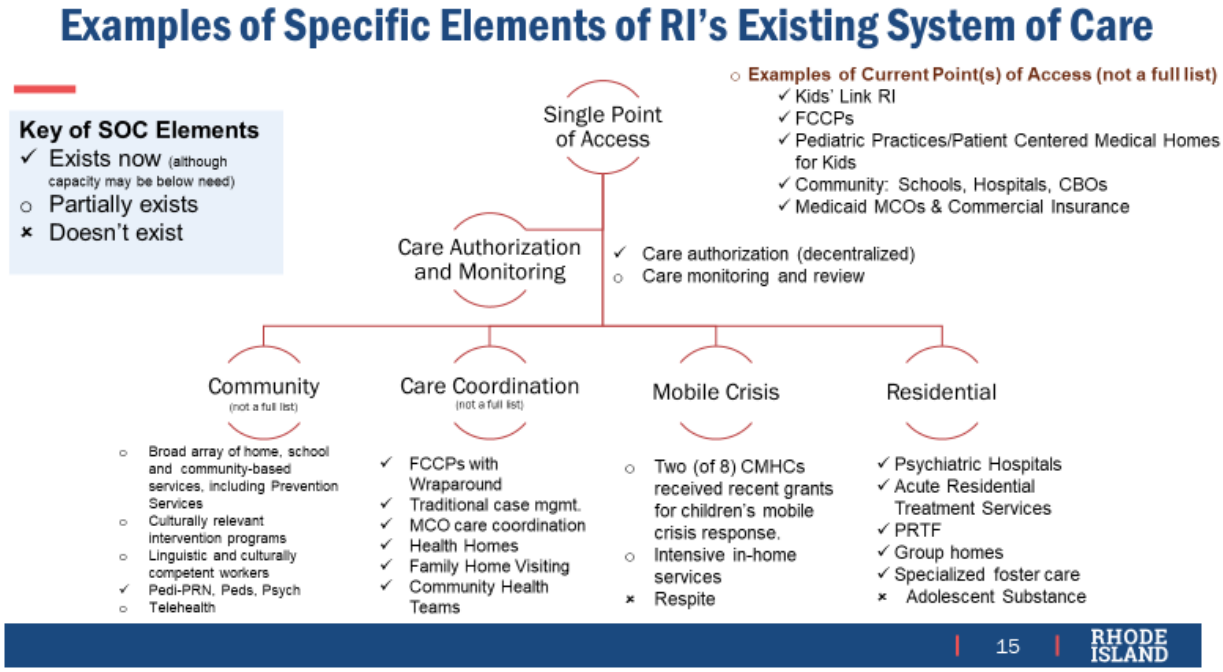
- Three of the Work Groups focus on the foundational components of the plan: Ensuring Equity, Transforming our Workforce, and ensuring strong Community Outreach and Education. (These are reflected in the red boxes below.)
- Four of the Work Groups focus on the Program Components of the plan: Crisis Continuum, Care Authorization, ensuring a strong Service Array, and Prevention (in the blue boxes).
- The Data System for Outcomes Measurement and Evaluation is a Connector Component of the Plan – in other words, the way that the plan ties the system components together. In addition, we see another Connector Component of the system in the Single Point of Access (addressed by the Crisis Continuum Work Group) (in the yellow boxes).

Figure 17: System of Care Visual Representation



Below is a representation of the current specific elements of Rhode Island's existing System of Care, noting where things are in place (but not necessarily at scale) and where things are partially or not at all available. Over the past three decades, Rhode Island has taken many steps towards developing and implementing a comprehensive system of care for children and youth. Rhode Island intends to build on previous efforts to improve access and services for children and youth and to also broaden the System of Care approach to incorporate elements of a population-based public health framework, strategies for integrating health and mental health care with a focus on alignment with pediatric primary care practices and eliminating disparities.

Figure 18: Detailed Elements of Rhode Island's Current System of Care



Rhode Island System of Care Activities and Strategies

The following pages are the heart of the plan for the Rhode Island Behavioral Health System of Care for Children and Youth.

We included separate planning charts for each of the key activities reflected in the visual above.

System of Care Key:
Program Components
Foundational Components
Connector Components

Program Components:

Prevention
Mobile Response and Stabilization Services
Service Array, including Intensive Home and Community Based Services
Care Coordination

Foundational Components:

Ensuring Equity
Workforce Transformation
Outreach and Education
Sustainable and Braided Funding

Connector Components:

Single Point of Access
Data Systems for Outcomes Measurement

The EOHHS planning team understands the critical importance of aligning the plan components. We list separate activities, for example under Mobile Crisis and Building a Strong Service Array, but we know that they are inextricably linked. Mobile crisis systems need strong services arrays to refer to and the service array benefits from having the mobile crisis system carry out initial assessments. Therefore, in the implementation of this plan, the components will be addressed together.

Another key part of the planning process is addressing the funding and sustainability of each of the plan components. EOHHS is working with the McKee Administration to complete budget requests for Fiscal Year 23, including proposals for federal American Rescue plan and Home and Community-Based Services funding. EOHHS will add the specific budget numbers into this plan when they are publicly available.

Implications for Planning:
The subject matter experts looking at the data began to lay out the implications for planning, encouraging Work Group participants to take the following recommendations into account:

- **Differentiating strategies on gender**. For those identifying as boys or young men, the focus may need to be on an anti-bias effort, with education on how behavioral health issues manifest themselves differently for boys. For those identifying as girls or young women, the focus may need to be on the right balance of in-person outpatient capacity versus telehealth, with the availability of specialized services. For those identifying as non-binary, we must be particularly aware of the services and care these Rhode Islanders need for their mental health, beyond either the questions of behavioral issues or in-patient versus telehealth care.
- **Location and Mode matters:** As we look at expanding the service array for our youth and young adults, we should consider bringing services to young people – literally meeting them where they are at with therapy at school, primary care, job training centers, and other community settings and organizations, speaking their language, and technology-enabled where relevant (text-based therapy; gamification; app-based clinical and social connection) rather than assuming all therapy needs to be talk therapy. In general, we should be thinking about where young people will feel comfortable getting services – and ensuring that school and community systems, e.g., transition age service hubs are aligned and integrated. We must also align the work in the community with children's pediatric or family doctor's offices, to ensure that we effectively integrate physical and behavioral healthcare.
- **We have a workforce shortage** in behavioral health support for children. We need to expand, specifically with culturally competent and linguistically appropriate clinicians including an emphasis on recruitment and treatment strategies. With the expanded advent of telehealth, we can find ways to locate providers who do not necessarily live in Rhode Island. And the state should explore strategies for the creation of pathways to support community behavioral health providers to work in school.
- **We lack general and specific in person capacity:** In general, we have a lack of capacity for in-person services – outpatient services and inpatient beds. However, as we build capacity, we should always move away from the most restrictive services (i.e., residential care) to prioritize community-based care.

In the planning charts below, we lay out goals, objectives, a description of the current system, outcomes and milestone, barriers and challenges, and alignment plans. For two of the areas of work – prevention and equity – we go into more depth on specific goals and objectives.

Program Components

Program Component Activity #1: Prevention

See below for Goals & Objectives.

CURRENT SYSTEM DESCRIPTION:

DEFINING PREVENTION IN THE CHILDREN'S BEHAVIORAL HEALTH SYSTEM OF CARE

Adapted from *The Evolution of the System of Care Approach for Children, Youth, and Young Adults with Mental Health Conditions and their Families* from the Institute for Innovation and Implementation at University of Maryland—School of Social Work.

Prevention, both primary, secondary, and tertiary can broadly be defined within the following specific type and groupings of activities:

- **Universal Physical, Behavioral, and Social Health Promotion for Children and Caregivers**
  - Health and Wellness Policy
  - Mental Health Promotion
  - Social Emotional Development
  - Protective Factors Provision
- **Universal Screening and Early Identification of Children and Caregivers (in partnership with physical healthcare providers)**
  - Developmental Screening
  - Behavioral Health Screening
  - Family Psychosocial Screening
  - Social Determinants of Health Screening
- **Enhanced Prevention for At-Risk Populations of Children and Caregivers**
  - Targeted Outreach, Engagement, and Retention
  - Additional Resource Provision
  - Transition Coordination
  - Severity Escalation Mitigation
- **Tertiary Prevention**
  - High-Risk Behavior Prevention
  - Prevention of the Onset of More Severe Conditions
  - Prevention of Recurrence via Strengthened Step-Down Care Coordination

Further, for a robust prevention program to exist within the children's behavioral health system of care, the following categorical areas for prevention must be resourced and include a combination of the activity types listed above:

- Mental health
- Substance use
- Physical health services
- Social and child welfare
- Educational
- Juvenile justice
- Recreational
- Vocational
- Transition age
- Early childhood

STRENGTHS OF PREVENTION IN THE CHILDREN'S BEHAVIORAL HEALTH SYSTEM OF CARE

In discussing Rhode Island's system with community partners, the following strengths were highlighted as essential building blocks upon which to further create and sustain a robust prevention program:

- Regional Prevention Coalitions
- FCCPs
- Health Equity Zones
- Federal grant supports including Project AWARE to increase awareness of mental health issues among youth, connect schools to community-based services and support adult capacity to identify and support youth mental health concerns. School-Based Mental Health Capacity to support recruitment, retention of school based mental health providers, and respecialization pathways for community based providers interested in working in schools. School-Based Climate Transformation to support schools to build more equitable and supportive school climates and common strategies in the implementation of Multi-Tiered System of Supports, social emotional learning, and mental health strategies to support student success.
- Youth Suicide Prevention program, including Signs of Suicide curriculum, Youth Mental Health First Aid for adults and the development of a model policy for school districts per requirements of the Nathan Bruno Jason Flatts Act.
- Partnership with Yale Center for Emotional Intelligence on statewide education community access to a 10 hour course entitled *Social and Emotional Learning in Times of Uncertainty* and *Stress: Research-Based Strategies*. Support for the RULER program, a district/school wide approach to social and emotional learning.
- PCMH-Kids
- Mental Health Clinic within Family Court
- SurveyWorks administered in all public schools to collect feedback from students, families, and educators about school culture and school climate across the state.

OPPORTUNITIES TO STRENGTHEN PREVENTION IN THE CHILDREN'S BEHAVIORAL HEALTH SYSTEM OF CARE

In discussing Rhode Island's system with community partners, the following opportunities to expand and scale up were highlighted to further expand and resource a robust prevention program:

- Healthy Transitions Guidebook (need hub, portal, e-version of all of this to increase access)
- Mental Health Promotion (need statewide coverage; time limited, mostly grant funded)
- Substance Use (opioid versus non opioid focus; enforcement gaps—ENDS, alcohol; intentionality; marijuana perceptions; targeted communications by audience; safe medical uses)
- Social and Child Welfare Supports
- Wraparound services for all
- Educational Systems (Expanded learning, COZ, and after-school programs that connect students to caring adults
- Health Services (see recommendations; equity, coverage; preventative care gaps, sb-health centers, medical model mind shift)
- Youth Transitions (need to optimally sustain cohorts; resolve up to 21 versus adult at 18 system issue; provider-Medicaid payment-service delivery alignment)
- Juvenile justice (discharge transition and prevention)
- Yale Center for Emotional Intelligence Educator Well Being Playbook Pilot effort.
- Adoption of a Multi-Tiered System of Supports framework in schools statewide for school improvement efforts aimed at academic, social, emotional, and behavioral supports.

NEEDS FOR PREVENTION IN THE CHILDREN'S BEHAVIORAL HEALTH SYSTEM OF CARE

In discussing Rhode Island's system with community partners, the following needs to gather feedback on and plan for in a more purposeful way were highlighted to complement existing strengths and opportunities and create a comprehensive prevention program:

- Vocational Programs
- Recreational Programs
- Connecting physical and behavioral health – with examples – substance use and chronic disease
- Widespread education about prevention and resources in multiple modalities and languages
- Commercial and Medicaid reimbursement for prevention services (e.g., lack of a diagnosis, explore Z-codes, resolve billing for only medically necessary versus universal prevention activities)

DATA SOURCES:

SUGGESTED DATA SOURCES PREVENTION IN THE CHILDREN'S BEHAVIORAL HEALTH SYSTEM OF CARE

- Bradley and Project Aware Data for Mental Health First Aid
- Prevention Block Grant
- Healthy Transitions Grant

- Family Home Visiting and MomsPRN Programs
- DCYF data on FCCPs
- Medicaid and APCD claims data
- EPSTD Medicaid Data
- PCMH-Kids Practices, PCMH-Kids IBH Practices
- School-Based Data via KIDSNET
- Need Better Data for Screening and Follow-Up, particularly non-Medicaid
- RIDE school health data
- Preschool enrollment data
- All-day kindergarten data
- FHV data
- Hassenfeld multi agency data
- Ecosystem data
- Incredible Years data

FLAG: MOST IMPORTANT PLANNING ALIGNMENTS

- Please see alignments in Appendix 5: Program Component #1 Detailed Plan: Prevention

BARRIERS/CHALLENGES:

- Lack of dedicated funding and current funding is mostly grant-based
- Not enough and not consistent equity in prevention activities
- Family caregiver focus is needed in a comprehensive way that can be implemented simultaneously
- Workforce shortages
- Siloed funding which limits a broader view, strategy, and shared perspectives
- Social isolation and reduced community cohesion
- Need to leverage research and academic partners and opportunities
- Ensuring equity and engaging appropriately our minority populations
- Self-pay and other billing issues for prevention
- Policies focusing on complex, high-cost patients versus universal prevention
- Housing and Employment and Transportation barriers for families
- Interagency CBHSOC Prevention Coordination and Information Sharing (cross sector collaboration)
- Comprehensive Prevention Strategy and Legislation
- Local Buy in and Place-Based Initiatives
- Awareness and understating of issues related to education based and medically driven funding for behavioral health care

POLICY CHANGES REQUIRED:

SUGGESTED DATA SOURCES PREVENTION IN THE CHILDREN'S BEHAVIORAL HEALTH SYSTEM OF CARE

- Creating billable services for prevention or perhaps a prevention PMPM (through MCOs)
- Mini-grants for prevention – perhaps a fund?
- Shift investments towards prevention
- Budget-related policies
- SDOH and Emergency Assistance Funding/Provision (car fix, clothing, etc.)
- Local involvement and responsibilities (also enabling authorities)

TIMELINE:

- See details in Appendix 5: Program Component #1 Detailed Plan: Prevention

RECOMMENDED ALIGNMENTS WITH OTHER PLANNING PROCESSES:

- Children's Cabinet Strategic Plan
- Regional Prevention Coalition Plans
- Health Equity Zone Action Plans
- Governor's Overdose Prevention and Intervention Taskforce
- Overdose Evidence Update and Strategic Program Review
- Learning, Equity, and Acceleration (LEAP) Recommendations
- Bruno-Flatt Act Requirements
- Juvenile Justice Report
- Families First Prevention Plan (DCYF)

The next page summarizes the goals and objectives for prevention. For additional details, please see Appendix 5: Program Component #1 Detailed Plan: Prevention

Goals	Objective 1	Objective 2	Objective 3	Objective 4
1: Mental Health Conditions	By January 2022, develop and begin implementation of a comprehensive awareness and outreach plan to educate, train, and reduce stigma on mental health and wellness—with a specific focus on reaching marginalized populations and/or those underutilizing the system of care.	By June 2022, implement strategies to sustain, expand, and maximize use of existing mental health prevention services, resources, and opportunities for specific, identified population groups.	By September 2023, scale up investments in student assistance, social emotional learning, peer support, and mental health first aid resources within all school districts in Rhode Island.	
2: Substance Use	By January 2022, expand substance use prevention efforts for youth, parents, and schools.	By January 2022, maintain and/or expand targeted community-level inventions to reach indicated populations and/or address emerging substance use needs.	By January 2022, develop a sustainable funding plan to continue and/or scale up critical substance use prevention activities across the lifespan that meet a demonstrated need or builds upon best practice.	
3: Health Services	After October 2021, continue health screenings for all children and youth in schools and at pediatric practices and evaluate need for increased screening for key areas in post-pandemic recovery, such as childhood lead poisoning. Note: the RI Department of Education and the Rhode Island Student Assistance Services are working with Bradley Hospital and KidsLink using	By June 2022, evaluate need and plan for expansion of health- and/or special healthcare need-specific health service programs for specific, identified population groups, such as those with Long COVID, disabilities, and chronic health conditions.	By September 2023, scale up investments in comprehensive medial homes, social emotional screening, toxic stress identification and referral mechanisms, and obesity prevention for children and youth in Rhode Island—particularly those families who do not frequently engage in care.	By June 2022, develop a plan to strengthen psychiatric health services, discharge planning, and related supports to incorporate additional prevention strategies and mitigate more severe recurrence of illness.

	the Columbia scale for screening.			
4: Social and Child Welfare Supports	By January 2022, increase awareness of existing, available, and recommended community-based resources (such as Health Equity Zones, Family Resource Centers, pediatric screening, and other programming suggestions) to address social and child welfare concerns using a place-based lens.	By June 2022, resource and implement additional social and child welfare activities aimed at identifying, reaching, servicing, and retaining involved and at-risk families to help children and youth thrive.	By September 2023, scale up investments in parent education, family services, peer support pilots, enhanced children and youth programming, and enrichment activities in Rhode Island.	
5: Educational Systems and Programs	By June 2022, develop guidelines and plans to assist schools educate, train, and empower youth to reach their full potential, care for one another, and understand behavioral health concerns.	By June 2022, identify needs and develop plans to further resource Individualized Education Plan services and apply learnings from the mental health capacity-building grant to other districts within a Multi-Tiered System of Supports Framework.	By September 2023, scale up investments in pre-kindergarten, social emotional learning programs, quality day care services, school-based services/residencies, Multi-Tiered system of Supports framework, and behavioral health career programs within all school districts in Rhode Island.	By June 2022, expand partnerships with state, community and academic partners to support districts in meeting the social emotion and behavioral needs of youth and families
6: Juvenile Justice Programs	By January 2022, continue, build, and expand partnerships and innovative evidence-based programming to prevent and/or transition out of justice system involvement			

	for Rhode Island children and youth.			
7: Recreational Programs	By January 2022, increase visibility of and no-barrier access to existing community-based recreational activities that are children-, youth-, and family-engaging.	By June 2022, develop plans to invest in community recreation, youth leadership, and drop-in spaces to increase access to developmentally-appropriate recreation.		
8: Vocational Programs	By September 2022, assess, evaluate, and recommend changes to the diversity, availability, and awareness of vocational, career, and technical programs in Rhode Island.	By September 2022, implement non-traditional and/or supportive strategies to expand the development of life skills, soft skills, and other strengths among the state's youth.		
9: Youth Transitions to Adult Services	By January 2022, develop an outreach and engagement plan for educating families, caregivers, providers, and youth about the unique needs of transition-aged youth, services available, and resources that exist to ensure no gaps in needed services arise.	By June 2022, complete a resource map of existing prevention resources and opportunities to engage youth who are identified populations at-risk of uncoordinated transitions in systems of care.	By September 2023, scale up investments and resources that promote coordinated healthy transitions in Rhode Island.	
10: Early Childhood Programs	By June 2022, implement strategies to sustain, expand, and coordinate prevention services, resources, and opportunities for systemically marginalized	By September 2022, scale up quality investments to support families throughout early childhood to promote healthy development for infants		

	populations within early childhood environments.	and children in Rhode Island		
11: Overarching Prevention Efforts	By September 2022, identify existing plans and/or develop plans to implement overarching support and assistance programs that address the socioeconomic and environmental determinants of health affecting Rhode Island families.			

Program Component Activity #2: Ensuring a responsive Children/Family Mobile Crisis function within the system, aligned statewide with other crisis response functions

GOAL: Establish mobile crisis services for children in Rhode Island.

Presently in Rhode Island, a gap exists with interventions designed to immediately work to deescalate and ameliorate crisis before more restrictive and costly interventions become necessary. The goal for a Mobile Response and Stabilization Services (MRSS) is to have services that can intercede before urgent behavioral situations become unmanageable and costly emergencies.

MRSS is designed to

- reduce unnecessary ED visits
- reduce placement disruptions
- reduce overall system costs
- reduce out-of-home placements
- reduce disparities
- increase juvenile justice diversion

Objective: As noted in the Behavioral Health System Report, written by Faulkner Consulting Group and Health Management Associates, Rhode Island is proposing to implement a statewide approach to mobile crisis to satisfy the larger CCBHC continuum requirement efficiently and respond to both adult and children in Rhode Island (and their families) who may experience behavioral health crisis. EOHHS will be convening a Mobile Crisis Services Task Force beginning in September of 2021, comprised of Medicaid, BHDDH, DCYF, and SUMHLC. This Mobile Crisis Services Task Force will be facilitated by an outside consultant with subject matter expertise in mobile crisis service program design. This Mobile Crisis Services Task Force will be responsible for the development of recommendations and standards for mobile crisis for both adults and children throughout the state. There will need to be close alignment with the EOHHS Mobile Crisis Task Force planning and Children's Behavioral Health System of Care planning for mobile crisis services as there are differences in service needs that will be incorporated.

CURRENT SYSTEM DESCRIPTION:

Presently in Rhode Island there is very little mobile crisis response capacity for children and youth. In 2018, there were 2,865 emergency department visits and 1,864 hospitalizations of Rhode Island children with a primary diagnosis of mental disorder. In 2018, an interagency working group examining ED and psychiatric hospitalization usage for children and youth found that the total number of ED visits for children and youth had increased more than 60% over a decade. The group determined that families thought that turning to an ED or their local police department was their only option for help when their children experienced a behavioral health crisis. Rhode Island's overarching goal is to create a more unified and cohesive system to assist and guide families where to get help and to ensure that their children receive the highest quality care in the least restrictive way possible.

Today, there is one mobile crisis service provided through a CCBHC expansion grant received by Thrive and Community Care Alliance, with Tides Family Services as the subcontracted vendor to provide this service. This grant only allows for 75 families to be served per year. There are other providers who provide mental health professionals in police ride-along services, but these are not stand-alone mobile crisis services staffed only with mental health professionals. BH Link has some mobile crisis capacity for individuals ages 18 and older, however this is not a 24-hour service. To fully implement MRSS statewide will require significant capacity building.

It is important to note here that there is a lack of other behavioral health capacity and not enough services across the service array. (Please see Page 53 for a description of the Service Array planning for the System of Care.) Unless services are enhanced, implementation of MRSS will likely lead to an increase in demand for behavioral health services from an already overburdened system, resulting in children being referred to long wait lists rather than effective services. Service expansion should take place simultaneously to the system infrastructure enhancements.

MAJOR ACTIVITIES AND PRIMARY AUDIENCE:

The primary activity will be to develop state-wide Mobile Response and Stabilization Services for children, youth, and families that meet their service needs. The CBHSOC Crisis Continuum Work Group members are recommending that the following child and family specific best practices for Mobile Response and Stabilization Services (MRSS) as identified in the "2018 National Association of State Mental Health Program Directors (NASMHPD): Making the Case for a Comprehensive Children's Continuum of Care:"

- The crisis is defined by the caller.
- Services are available 24 hours a day, 7 days a week.
- Rapid response. (e.g., Connecticut by phone or face-to-face within 45 minutes, Massachusetts face-to-face within 1 hour)
- Serve children and families in their natural environments, for example, at home or in school.
- Immediate de-escalation/stabilization of the crisis along with development of an individualized, strengths-based safety/crisis plan with the child and family.
- Can serve as gatekeepers for admission to higher levels of care, such as inpatient care.
- Include specialized child and adolescent trained staff and do not rely on predominantly adult-oriented crisis response workers.
- Standardized screening and assessment.
- MRSS teams have immediate access to psychiatric consultation for clinical support and medication review.
- Provide stabilization services after the initial acute intervention. These services may include in-home supports, respite care, and short-term care coordination.
- This stabilization component of MRSS may be provided over the span of a few days or over several weeks (e.g., MA up to 1 week, CT up to 6 weeks).
- Coordinate care with existing providers.
- Build on natural support structures and reduce reliance on hospitals and formal crisis response systems.
- Connect families to follow-up services and supports, including transition to needed treatment services.
- Standardized core training curriculum with a race equity lens.

- Have specialized teams and/or training for serving:
  - I/DD children and youth
  - LGBTQ+ Populations
  - Children and youth in foster care
- Is accessible to all children in the state, regardless of system involvement, insurance status, or geographic location.

SERVICES:

- A rapid response mobile crisis intervention that provides children and youth with crisis assessment, intervention, and stabilization services. Serves children and families in their natural environments, for example, at home or in school.

OUTCOMES, METRICS, AND MILESTONES:

- Reduction in use of restrictive forms of care (e.g., psychiatric hospitalizations, residential treatment centers and repeat hospitalizations)
- Reduction in # of ED visits and repeat visits
- Reduction in overall system costs
- Reduction health disparities in race, language, and physical ability
- Family satisfaction with the services.

DATA SOURCES:

- Map current points of access (emergency rooms, Kids Link, urgent care, child psychology/psychotherapy) against incidence of behavioral health crisis need by zip code
- Behavioral health-related ED visits, urgent care, and IP admissions
- DCYF and 911 calls for children's behavioral health reasons
- Mobile Crisis vendor data

FLAG: MOST IMPORTANT PLANNING ALIGNMENTS

- Workforce and Broad Service Array

BARRIERS AND CHALLENGES:

- A core component of MRSS is to assist youth and families in accessing and linking to ongoing support and services, including intensive clinical and in-home services. At present, there is insufficient capacity of services to implement after MRSS, most critically intensive in-home services.
- The development and implementation of MRSS for children needs to be aligned with other state and federal initiatives including the EOHHS Mobile Crisis Services Task Force that is responsible for the development of recommendations and standards for mobile crisis for both adults and children throughout the state, and the 988 Federal initiative.

- Workforce issues are a critical area that needs to be addressed. Rhode Island is currently experiencing a severe shortage of mental health professionals. There are many workforce challenges, such as consistent underfunding and difficulties attracting and retaining a stable, highly trained, workforce. For mobile crisis services, CMS is recommending that states enhance crisis provider reimbursement rates to reflect cost of making 24/7 "on call" mobile crisis services available to Medicaid enrollees through the 85% enhanced federal match on these services for three years (beginning in April 2022). In addition, there is a significant need to identify and recruit professionals into the workforce to enhance its representativeness relative to the population served, with respect to race, ethnicity, culture, and language

POLICY CHANGES REQUIRED:

- Fiscal policies w/insurance (e.g., Medicaid funding for overlapping services, etc.)
- Rate setting policies w/in the state.

TIMELINE CONSIDERATIONS:

- Implementation of 988 (July 1, 2022)

RECOMMENDED ALIGNMENTS WITH OTHER PLANNING PROCESSES

- Statewide Mobile Crisis Planning
- 988 Implementation

Program Component Activity #3: Ensuring a Strong Service Array

GOAL:

Develop and expand services and supports based on the System of Care philosophy and approach by ensuring investments in an adequate, responsive, and broad service array.

CURRENT SYSTEM DESCRIPTION:

- *Prevention*
- *Identification of Need*
  - *Assessment/Evaluation*
- *Informal Supports (Not State/Insurance funded)*
  - *Family members*
  - *Family Resource Centers **(GAP)***
  - *Religious Organizations*
  - *Grassroots Organizations*
- *Formal Supports (State/Insurance funded)*
  - *Assessment/Evaluation*
  - *Pediatric and Family Practice Physicians*
  - *Emergency/Crisis Response/Services **(GAP)***
  - *School Behavioral Support Services*
  - *General O/P*
  - *Kin services/support*
  - *Adoption services/supports (pre/post)*
  - *Psych consults to Pediatricians (on-call)*
  - *In home Clinical (incl. Therapeutic Mentors-PASS-like) **(GAP)***
  - *Enhanced in home*
  - *Hospital*
  - *Out of home (residential-short/longer term)*

MAJOR ACTIVITIES AND PRIMARY AUDIENCE:

- Engage families before the final determinations for the SOC
- Seamless funding – EOHHS, MCOs
- Enhance rates – EOHHS, MCOs
- Alignment with pediatricians and family practice physicians
- New crisis response (MRSS) – EOHHS, MCOs, Service Providers

- Enhance home based – more clinically focused, flexible, and responsive to demand – EOHHS, MCOs, Service Providers
- Enhance school and Out-Patient services – RIDE, EOHHS, MCOs, Service Providers, including expanding Project Aware's supports for school-based mental health services for children and families, the School Climate Transformation project funding facilitative leadership practices, and activities of our School-Based Mental Health grant for recruitment and retention of school-based mental health staff.
- Residential services for specific populations – EOHHS, MCOs, Service Providers
- Improve family clinical services– EOHHS, MCOs, Service Providers
- Establish outreach plan for SOC to community - EOHHS, MCOs, Service Providers
- Integrate Standardized tools, CANS, Shape Assessment (UMD), SDOH screening (Healthlinks), ACES (modified?), Columbia Suicide Severity tool, etc. - EOHHS, MCOs, Service Providers
- Established Virtual resource portal
- Updated weekly by providers

SERVICES: Click on the documents below for more information


Childrens BH SOC Service Array - 7.8.20


FV-Resource-Guide -English-FINAL-10.2


BHDDH November 2019 RIYOUTHTRAN

OUTCOMES, METRICS, AND MILESTONES:

- Decrease in Hospitalizations (both children and adults)
- Decrease in the # of ED visits (both children and adults)
- SOC measures? (other states)
  - Clear benchmarks
- Eliminate wait lists
- Improve time lapse for service engagement
- Decrease Out of State placements
- Decrease in Child Abuse/Neglect
- Decrease in Juvenile Justice – less arrests and incarcerations
- Decrease in overdoses (both children and adults)
- Stable workforce (decreased turnover)
- Informed Consumers on the SOC
- Consumer voice in all decision making
- Increase the number of school districts with behavioral health support that meet the needs of the school community.

DATA SOURCES:

- APCD
- Ecosystem
- KidsNet
- KidsCount

FLAG: MOST IMPORTANT PLANNING ALIGNMENTS

The development and expansion of a flexible and responsive service array will only be accomplished by ensuring there is an adequately funded workforce. RI is consistently challenged with losing its workforce to neighboring states that have better reimbursement rates and therefore higher wages. Without a stable workforce, RI will continue to experience access issues to less restrictive service settings and over rely on higher levels of care like hospitals and congregate care settings.

BARRIERS AND CHALLENGES:

- Workforce – specialized Psychiatrists, Doctoral level
- Community awareness – coordination of care
- Funding
- Details for Outcomes (TBD)

POLICY CHANGES REQUIRED:

- The State of RI must determine how to combine funds from the various state agencies (Medicaid, DCYF, BHDDH, RIDE, etc.) in order to remove the barriers and criteria that limits service delivery to only specific populations.
- Legislation may be required in order to support the System of Care (minimally to ensure local cities/towns participate)

TIMELINE CONSIDERATIONS:

- FY23 and/or FY24?
- There is a sense of urgency.
- Understanding of longer term care for behavioral health needs (no quick fixes)

Program Component Activity #4: Expanding Intensive Care Coordination

GOAL:

The goal of expanding access to intensive care coordination/wraparound facilitation is to promote long-term wellbeing for children and families who are confronting serious behavioral health challenges and who are in need of multi-systemic help while also reducing racial and ethnic inequities in access to high quality behavioral health care and in children's behavioral health outcomes.

The objectives are to …

- Expand high fidelity wraparound facilitation that supports a family to direct their own care and use social and professional supports so that each family can ultimately sustain positive connections and promote wellbeing without long-term assistance from professionals.
- Ensure that the entire team working with a family is working together according to the family's voice and choice.

CURRENT SYSTEM DESCRIPTION:

Many children and families have behavioral health needs that can be identified relatively easily, and in many instances, these children and families can be quickly and directly referred to service providers. Other children, however, are experiencing serious emotional and/or behavioral disturbances and multiple system involvement. These children and their families require intensive coordination of services and supports. High fidelity wraparound is a care coordination model that is considered a best practice for systems of care. Traditional case management, Managed Care Organization care coordination or health home approaches are often not sufficient for children and youth with significant behavioral health challenges.

Currently, high fidelity wraparound facilitation is provided to roughly 600 families at any one time through the DCYF-contracted Family Care Community Partnerships (FCCPs). Five regional FCCPs are currently in operation in the state.

MAJOR ACTIVITIES AND PRIMARY AUDIENCE:

Population served: Wraparound/intensive care coordination should help families for whom …

- Traditional services and case management are not sufficient or flexible enough
- Multi-system involvement is needed, including engagement with schools
- The right interventions and supports are not necessarily clear
- There is a risk of prolonged involvement with high end behavioral health services and psychiatric hospitalization

Health insurance should not be a barrier to accessing wraparound facilitation (i.e., a family can access the service no matter their health coverage)

Major Activities:

- Determine the method to expand wraparound (e.g., procurement) and build on existing FCCP wraparound
- Assess how to integrate clinical services within the team approach, including information back to the child's physical health provider

- Map out services and supports to be utilized through wraparound, including school and community-based efforts
- Follow preferred method (e.g., procurement) to expand access and develop necessary policies and procedures
- Engage in outreach to promote wraparound
- Establish a real-time feedback look to include family/youth advisory groups

SERVICES:

As defined by the National Wraparound Initiative, "wraparound differs from many service delivery strategies in that it provides a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. Wraparound puts the child or youth and family at the center. With support from a team of professionals and natural supports, the family's ideas and perspectives about what they need and what will be helpful drive all of the work in wraparound." The wraparound approach that is currently provided instate by the FCCPs would be expanded.

OUTCOMES, METRICS, AND MILESTONES:

The following outcomes and process measures could be used to assess success and determine what service improvement are needed. Each metric should be broken down by race and ethnicity so that the impact of wraparound/intensive care coordination can be assessed for racial and ethnic inequities:

- # of referrals and families served
- Referral source
- Family demographics
- Time from referral to first face-to-face contact
- Length of involvement
- % of families closed with all, most or partial wrap goals met
- % of families for whom effective supports were established
- % of families who are able to receive services with the amount and frequency that is required
- Improvements on CANS domains or on other functional assessment tools
- % of children with subsequent maltreatment
- % of children who subsequently enter out-of-home care
- % of children with subsequent psychiatric hospitalization
- School enrollment (and ultimately school readiness)
- % of developmental screenings completed
- % accessing public benefits who are eligible (e.g., SNAP)
- Caregiver employment
- Family and youth satisfaction

DATA SOURCES:

Most measures are already tracked and reported out through DCYF's RIFIS and RICHIST systems. Data sources for some measures, mainly those related to school readiness and caregiver employment, will need to be developed. Additionally, family and youth satisfaction surveys will need to be developed and administered. Surveys were done in the past and can serve as a starting point for moving forward.

FLAG: MOST IMPORTANT PLANNING ALIGNMENTS

Expanding wraparound/intensive care coordination will be foundational to the rest of the system of care. As such, it would be closely tied to …

- Mobile crisis and single point of entry
- The broader service array
- Workforce transformation
- Community outreach and education
- Data systems
- Prevention

BARRIERS AND CHALLENGES:

Data/IT systems:

- Getting multiple data systems to talk with each other
- Having one centralized plan that follows a family (so there is consistency and families don't have to explain over and over)
- May be able to build on Current Care, RIFIS or other existing systems

Workforce

- Workforce retention and high caseloads
- Time for professional development, training, and workforce support of wraparound facilitation staff specifically
- Need to ensure uniformity of high fidelity wraparound implementation and ongoing service delivery
- May be able to have multiple programs train together (e.g., wraparound & EI together) to ensure cross-sharing of ideas and best practices
- Need to ensure cross-state agency collaboration

POLICY CHANGES REQUIRED:

- Establishment of universal screenings to identify who might need intensive care coordination or other supports as well as to identify concerns before a behavioral health crisis.

TIMELINE CONSIDERATIONS:

- Have standard legislatively driven budget deadlines
- Need to research additional grant opportunities

Foundational Components

Foundational Component Activity #1: Ensuring Racial Equity & Eliminating Disparities

Please see Goals and Objectives below, for eight categories of equity we seek in the System of Care.

CURRENT SYSTEM DESCRIPTION:

The right to access quality health care for all populations regardless of the individual's race, ethnicity, gender, socioeconomic status, sexual orientation, or geographical location. This includes access to prevention, treatment, and recovery services for mental and substance use disorders. In conjunction with quality services, this involves addressing social determinants, such as employment and housing stability, insurance status, proximity to services, culturally responsive care – all of which have an impact on behavioral health outcomes.

Up to 80 percent of our health is determined outside the doctor's office and inside our homes, schools, jobs, and communities – the places where people are born, grow, live, work, play, age, and pray. Conditions in these places – called the social, economic, and environmental determinants of health – have a greater influence on health than other factors, like genetics, individual choices, or access to healthcare. They are shaped by forces like structural racism, poverty, and the distribution of money, power, and resources at the global, national, and local levels.

Racial inequities persist in every system across our country, from healthcare to education, criminal justice, housing, and the economy. These inequities can't be explained by differences in socioeconomic status. Rather, they result from powerful forces in our systems and institutions. To improve health outcomes for everyone we serve, public health must make advancing racial equity a core part of its mission. Other Forms of Marginalization and Oppression include: Ageism; Classism and Colonialism; Sexism, Heterosexism, and Transphobia; Ableism; Saneism; and Sizeism.

In fact, the health of a community is directly connected to its economic and educational ecosystem. And the disparities in health are due to structural racism and other inequities. Below are unfortunate examples that this still exists today:

1. **Link between economic inequities and self-reported poor behavioral health:**
   There are multiple factors that can increase or decrease risk of a mental health or substance use disorder, but according to a 2018 article in the journal *Nature,* there is a significant body of evidence linking "…social and economic inequality and poor mental health. There is a social gradient in mental health, and higher levels of income inequality are linked to higher prevalence of mental illness." 2018. The authors present a raft of growing evidence connecting "…economic inequality and poor mental health (Friedli, 2009; Pickett and Wilkinson, 2010; Platt et al., 2017). Experience of socioeconomic disadvantage, including unemployment, low income, poverty, debt and poor housing, is consistently associated with poorer mental health (Silva et al., 2016; Elliott, 2016; Platt et al., 2017; Friedli, 2009, Rogers and Pilgrim, 2010). Mental health problems are particularly prominent amongst marginalised groups experiencing social exclusion, discrimination and trauma, leading to compound vulnerability (Rafferty et al., 2015). Greater inequality within societies is associated with greater prevalence of mental

illness (Wilkinson and Pickett, 2009; Pickett and Wilkinson, 2010), and economic recessions have had devastating impacts on population mental health (Platt et al., 2017; Wahlbeck and McDaid, 2012)."

2. **Links between structural racism, the economy, and behavioral health:**
Given the economic inequities as a result of race, Black, Indigenous, and People of Color (BIPOC) will be found in the groups at economic disadvantage to an analysis of Bureau of Labor Statistics Data by the Institute for Policy Studies Inequality.org project, Racial discrimination in many forms, including in education, hiring, and pay practices, contributes to persistent earnings gaps. As of the last quarter of 2020, the median White worker made 27 percent more than the typical Black worker and around 36 percent more than the median Latinx worker." And according to Rhode Island Kids Count, in 2019 Rhode Island's unemployment rate among White workers was 3.3%, compared to 4.6% for Black workers and 6.1% for Hispanic workers. Nationally, the unemployment rate for White workers in 2019 was 3.3%, compared to 6.1% for Black workers and 4.3% for Hispanic workers.

3. **Rhode Islanders with frequent mental distress and income:**
Specifically, America's Health Rankings reports that Rhode Islanders with Frequent Mental Distress (Percentage of adults who reported their mental health was not good 14 or more days in the past 30 days) was 7.2% for those making $75,000 a year or more, down to 14.5% for those making between $25,00 and $49,999 and 24.7% for those making less than $25,000.

4. **LGBTQ+ Communities and Mental Health:**[xiii]
According to Mental Health America, in 2018 "4.5% of the U.S. Population identifies as lesbian, gay, bisexual. or transgender and of those, over 39% reported having a mental health illness in the past year." (Note, 2021 data show that LGBT identification rose to 5.6% of the U.S. population.)[xiv]

   Mental Health America also noted: "LGBTQ+ teens are six times more likely to experience symptoms of depression than non-LGBTQ+ identifying teens. LGBTQ+ youth are more than twice as likely to feel suicidal and over four times as likely to attempt suicide compared to heterosexual youth. And forty-eight percent of transgender adults report that they have considered suicide in the last year, compared to 4 percent of the overall US population. Regarding access to treatment, approximately 8 percent of LGBTQ+ individuals and nearly 27 percent of transgender individuals report being denied needed health care outright. In mental health care, stigma, lack of cultural sensitivity, and unconscious and conscious reluctance to address sexuality may hamper effectiveness of care. And evidence suggests that implicit preferences for heterosexual people versus lesbian and gay people are pervasive among heterosexual health care providers."

5. **People with Disabilities and Mental Health:**
According to the Centers for Disease Control and Prevention (CDC), 61 million people in the U.S. (or 26%) live with a disability. One in three adults with a disability do not have a usual healthcare providers and one in three adults also have an unmet healthcare need because of cost in the past year.[xv] In addition, the CDC reports that, "An estimated 17.4 million (32.9%) adults with disabilities experience frequent mental

distress, defined as 14 or more reported mentally unhealthy days in the past 30 days. Frequent mental distress is associated with adverse health behaviors, increased health services utilization, mental disorders, chronic diseases, and functional limitations."[xvi]

6. **Inequities from COVID-19 have lasting impact:**
   Finally, the impact of COVID on child poverty has been severe. According to Rhode Island Kids Count, since the onset of the COVID-19 pandemic, Rhode Island's unemployment rate has surged higher than the worst levels in the Great Recession, and revenue is expected to decline dramatically in FY 2021. Loss of employment in low-income households is expected to impact economic mobility and have devastating long-lasting effects on children in poverty. Black and Hispanic households are projected to face the greatest increase in poverty, and racial and ethnic disparities may be exacerbated if people of color face greater employment disadvantages. The impact of COVID includes the stress of the enforced isolation and economic upheaval, the grief that so many Rhode Islanders feel upon losing loved ones, the way that the pandemic made evident and worsened structural racism, and the impact that it had on our overdose crisis.

These systems issues are more acute for communities of color, for whom **historical inequities and ongoing structural racism** have deprived them of equitable capital (recovery, financial, social), trust in institutions, and access to equitable services. As such, maintaining a focus on equity throughout the re-design of our children's behavioral health system of care in Rhode Island is critical.

DATA SOURCES:

To be determined based upon selected and funded activities

FLAG: MOST IMPORTANT PLANNING ALIGNMENTS

Ensuring equity in the System of Care demands that every program must be designed with a race equity lens, and that every Work Group must have equity as a main principle and every aspect of the system of care must be designed with an equity lens and reach our most marginalized children and families first. The Ensuring Equity Work Group can help facilitate that work, but is not solely responsible for the equity of the system.

BARRIERS/CHALLENGES:

- Structural racism pervading the system
- Implicit bias among providers of care
- Historic lack of funding and need to identify future funding
- Lack of access to culturally competent care, either because of the lack of providers or because of barrier in access to existing providers (insurance coverage, transportation, etc.)
- Lack of access to care in one's own language

POLICY CHANGES REQUIRED:

- Place-based investments in diverse communities and communities of color

- Performance measurement systems focused on identifying the disparities and inequities within programs
- Incentive and outcome driven rewards for programs to close identified disparities and inequities
- Bias training and education for providers of care in the children's behavioral health system

TIMELINE:

See Objectives Chart below.

RECOMMENDED ALIGNMENTS WITH OTHER PLANNING PROCESSES:

- CLAS Standards for Behavioral Healthcare
- Race Equity Toolkit

Goals	Objective 1	Objective 2	Objective 3	Objective 4	Objective 5
1: Race and Ethnicity	Destigmatize mental health within communities of color and address the historical injustices of criminalization of behavioral health disorders	Address racism and teach principles of equity to healthcare providers within the children's behavioral health system of care	Engage the immigrant community in behavioral health planning conversations	Work to change the inequities among Autism Spectrum Disorder populations	Increase the diversity of the provider population
2: Language Spoken	Ensure engagement of the Commission for the Deaf and Hard of Hearing community as it relates to behavioral health planning	Increase the linguistic diversity of the provider population	Ask and document patients' preferred language within behavioral health records and ensure access to appropriate translation services	Implement Cultural and Linguistically Appropriate Services (CLAS) standards and assessments for providers	Avoid jargon terms and acronyms
3: Sexual Orientation, Gender Identity, and Gender Expression	Ensure that 90% of pediatric healthcare, behavioral health, disability services, and mental health agencies meet the "Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients" a set of recommendations created by the LGBT Health Access Project, part of the Massachusetts Department of Public	Ensure that 90% of providers are trained on and follow evidence-based practices in health care for transgender and non-conforming people.	Ensure that 90% of behavioral, mental health, disability services, and pediatric healthcare providers are effectively able to navigate and normalize conversations about diverse sexual and gender identities and expressions, including minors' rights to confidential gender and sexuality health care services without parent/ guardian consent.		

	Health, and supported by the American Medical Association.				
4: Diverse Abilities	Educate the public and ensure that 90% of providers understand intellectual and developmental disabilities using a social model and incorporated with mental health, and apply this disability lens to all access, services, advocacy, and engagement conversations about behavioral health.	Ensure that virtual services are still accessible to people and communities who need them	Implement Multi-Tiered System of Supports statewide to support the academic and behavioral health needs of all youth		
5: Culture and Beliefs	Hold community focus groups to understand what behavioral health means to various population groups and their cultural norms/preferences	Engage the youth voice in planning, education, and communications activities through student associations and parent groups	Develop cultural competencies for providers in behavioral healthcare that underscore cultural norms of diverse populations, address both explicit and implicit biases, and include holistic approaches	Honor patient choice, as much as possible, when determining facility or home-based services	Create partnerships with non-traditional behavioral health support systems, such as places of worship
6: Socioeconomic and Environmental Determinants of Health	Ensure people in communities of color gain increased access to affordable, quality healthcare, including	Engage in the prevention of adverse childhood experiences and their effects through parental supports, social	Reduce stigma about receiving services and increase protective factors teaching children's awareness.	Ensure safe spaces in health care offices for immigrants	

	behavioral healthcare services.	connectedness, and efforts more globally			
7: Criminal Justice Involvement	Work to reduce bias against people youth and family members with a criminal background – Not letting the behavior define the person	Develop a juvenile hearing board or court system that considers trauma and mental health	Ensure that providers are training on and use affirmative language surrounding criminal justice involvement	Work to reduce inappropriate criminalization of behaviors and social groups by ensuring that providers understand and are self-aware of racial, ethnic, sex/gender, religious and other biases in the labeling of behavior as criminal.	
8: Foster Care and/or Adopted	Outline equity gaps in foster care/adoption that lead to loss of relationships, identity struggles, loss of culture/history, guilt for not feeling exclusively grateful, etc.	Create education training support for caregivers that will equip then with resources to support children.	Recruiting and retaining foster families of color.		

For additional details, please see Appendix 6: Foundational Component #1 Detailed Plan: Ensuring Equity.

Foundational Component Activity #2: Workforce

GOAL:

Workforce development partnerships between behavioral health provider agencies and educators to develop and offer training, education, experiential learning, and career awareness programs that recruit and prepare students and job seekers for jobs and careers.

CURRENT SYSTEM DESCRIPTION:

Here are the top 6 components of the existing system, including gaps and areas that need enhancement

- Critical workforce shortages
- Uncompetitive wages and benefits
- Lack of children's behavioral health career awareness among students and job seekers
- Limited career advancement opportunities
- Lack of cultural and linguistic competence and race equity among clinician workforce
- Rhode Island has many practices which integrate physical and behavioral healthcare – and we should add to the number of those practices

MAJOR ACTIVITIES AND PRIMARY AUDIENCE:

Recruitment

Workforce development partnerships between behavioral health provider agencies and educators to develop and offer training, education, experiential learning, and career awareness programs that recruit and prepare students and job seekers for jobs and careers.

Retention

Competitive wages and benefits, manageable workloads, healthy work-life balance, respect and recognition, professional development, and career advancement opportunities to sustain and retain the behavioral health workforce.

Training and Education

Career pathways, employer-recognized credentials, continuing education, professional development that support individuals to gain increased knowledge, skills, and earnings

Equity

Workforce equity, diversity, and inclusion at all levels of behavioral health organizations and occupations to provide a culturally and linguistically-competent and supportive environment for staff and clients.

SERVICES:

Recruitment

- Career promotion and outreach to students and job seekers

- Career & Tech high school program (especially in under-represented communities) to prepare students with employer-recognized credentials and bridge to higher education (e.g., RI Nursing Institute Middle College)
- Pre-employment training and experiential learning partnerships between employers and adult education/job training agencies
- Bridge *from* RI Promise program to 4-year behavioral health programs
- Pathways from high schools to Assoc Degree (e.g., CCRI Human Services Associate Degree and certificate programs) to 4-year behavioral health programs
- Pathways to licensure for behavioral health paraprofessionals in the workplace (e.g., tuition waivers, paid educational leave, supportive services)
- Alternative academic pipelines - respecialization (e.g., from School of Education for those who decide not to pursue teaching)
- Financial incentives for private practice clinicians to pick up patients for publicly-funded agencies to address shortage of clinicians
- Expedite/centralize credentialling of new clinicians by health insurers to shorten time from licensure to practice
- Expanded loan repayment programs, residency programs, tax credits programs to improve hiring in health professional shortage areas

- Hiring bonuses:
    - Will be needed to improve recruitment and compete in a tight labor market
    - Should be structured to minimize "job hopping"

Retention

- Rates and wages:
    - Increase provider rate increases to boost wages to keep pace with growth of RI minimum wage
    - Include wage pass-through requirements in rate increases
    - Mental health wage parity for home and community services
    - Avoid wage compression by increasing wages of supervisors, managers, clinicians, etc.
    - Retention bonuses that reward longevity with same employer

- Career pathways (in addition to items list above under recruitment):
    - Competency-based apprenticeships with wage progression
    - Continuing education and professional development linked to advancement in credentials, skills, roles, and wages
    - Funding for "release time" / back-fill to cover trainee
    - Supervisor training and development
    - Alternative pathways to credentialing and licensure (e.g., work experience vs academic credits)

Equity initiatives (in addition to those listed under recruitment & career pathways):

- Equity-based health professional loan repayment programs
- Targeted tuition waiver and paid educational leave programs

- Alternative pathways to clinical certification and licensure
- Expanded training, employment, and funding of peer support roles

Other

- Expand telehealth capacity (technology, training, reimbursement) to increase access to clinical care

OUTCOMES, METRICS, AND MILESTONES:

Retention: Reduced employee turnover, vacancy rates, shorter time to fill vacancies, increased continuity of care, increased employee satisfaction, and reduced wait time for services

Workforce development: # and type of workforce credentials, internal promotions

Equity: race equity at all levels of organization, diversity within licensed workforce, increased culturally and linguistically-competent care

Workforce-sensitive client outcomes: client satisfaction, reduced use of institutional settings, reduced 911, ED visits, lower costs, etc.

DATA SOURCES:

Bureau of Labor Statistics/DLT
RIDOH licensure data
BHDDH; provider agencies
Exploring potential data-sharing opportunities

FLAG: MOST IMPORTANT PLANNING ALIGNMENTS

All Work Groups

BARRIERS AND CHALLENGES:

- Reimbursement rates are insufficient to grow and sustain a quality workforce.
- Licensure and scope of work requirements limit workforce supply
- Poor workforce data undermines workforce planning efforts
- Delays in credentialling of newly-licensed clinicians by insurance companies reduces supply of available clinicians

POLICY CHANGES REQUIRED:

- Increase provider reimbursement rates with wage pass-through requirements
- Develop payment models that support and reward career advancement
- Expand paid internship opportunities for students

- Expand health professional loan repayment funds; prioritize diversity and equity
- Establish data-sharing agreements between RIDOH licensure and DLT wage records
- Review and revise licensure requirements to increase supply; consider alternative pathways to licensure

TIMELINE CONSIDERATIONS:

Short-term: Increase reimbursement and wage rates
Mid-term: Develop provider-education partnerships to strengthen career pathways for students, paraprofessionals, and clinicians
Long-term: Review and revise licensure and scope of work requirements

Foundational Component #3: Community Outreach and Education

GOAL:

1. Share information with all Rhode Island families about how they can get help when their child is experiencing a behavioral issue or crisis
2. Create a Champion network for community leaders to engage in, to share information about the System of Care. Include peer to peer navigation for information and education
3. Make sure Rhode Islanders, and especially Rhode Island families, are aware of the broader System of Care and how it can help families, ensuring that community members understand that the system is for all Rhode Island families and not just those involved with DCYF
4. Create a feedback loop so parents can provide the state with information about how the System of Care is working – or what is not working for them - and how they can participate in our evaluation of the system.

CURRENT SYSTEM DESCRIPTION:

There are multiple community and state parent education and engagement channels:

State-sponsored, including (but not limited to):

- RIDE, including Local Education Advisory Committees (i.e., PTAs or PTOs) and the 21st Century Learning Centers and Child Opportunity Zones
- Kids.ri.gov
- BH Link
- Health Equity Zones
- RIDOH and its provider newsletters
- Medicaid's provider newsletters
- BHDDH Open Beds website

Community-focused, including (but not limited to):

- Bradley Hospital/Lifespan
- CNBC – Children's Neurodevelopmental Center
- KidsLink
- Local/State libraries
- Parent Support Network – parent engagement and advocacy
- Pediatrician offices/Patient Centered Medical Homes Kids (PCMH Kids)
- Providers in general – Olean Center, Providence Center, etc. and PCPs who do developmental screenings
- RI Parent Information Network (Family Voices, PTIC, call center, online resource center)
- RI Student Assistance Services – Education on resources available for families and how to reach them
- The Autism Project

- Youth Pride

MAJOR ACTIVITIES AND PRIMARY AUDIENCE:

1) Champion Recruitment: Recruit allies who will assist in supporting the System of Care's continuum of care, building system components, and actively spreading the word about the system to providers, parents, and advocates. We will prioritize champions based on the system need at the time, but will always recruit a diverse group of families and others with lived experience to be a part of this process.
2) Champion Training: Providing messaging, including an elevator pitch and culturally and linguistically competent promotional materials in multiple language; creating a train the trainer curriculum, and a process for them to submit feedback to the System of Care.
    - Create a budget for Champion Support – gift cards, meetings supplies, etc.
    - Create an online process for feedback from Champions
3) Gather information about the system from people with lived experience
    - Working with the Ensuring Equity Work Group, procure professionally run focus groups for insight into system of care planning

Primary Audiences for Champion Recruitment – The Outreach Work Group has been creating a broad list of potential participants in the Champion process. The Work Group will focus on engagement by population, geography, and language spoken, to ensure a broad diversity of participation from the following categories of community partners:

- Caregivers – Parents/grandparents/foster parents, etc., including families with children with a developmental disability, foster parents, LGBTQ+ families, Latinx families, families with medically fragile children, families with children with special health care needs, families of children being discharged from hospitals (including Bradley)
- Youth
- Providers of services
- Other health-based institutions
- Businesses and business-related organizations
- Community organization and community leaders, with a focus on organizations actively carrying out race equity work and activities to eliminate disparities
- Faith community leaders
- Institutes of Higher Education
- Narragansett Indian Tribe
- Neighborhood organizations
- Organizations within the justice system
- Policy-makers
- Schools and school-related organizations
- State agencies

Please see **Appendix 3** for the current list of specific organizations on the Champion Recruitment list. The list will evolve throughout the planning process.

SERVICES:

Messaging:

- Broad educational messages: here's the system we're working to build, here's where families can go for help, here's why a system is important
- Specific messaging:
    - Do you know someone who needs help? Send them here.
    - Do you need help? You are not alone. Here is who you call.
    - What to expect when I do call? Packet of information for families

Throughout these messages, we will ensure cultural and linguistic competency: Messages in multiple languages – and sending people to the right organizations who can meet the family's needs

Channels for Communication for a culturally and linguistically competent promotional campaign for marketing with resources for parents

- Social marketing tools to build a broad base.
- Paid media
    - Social media
    - Radio
    - TV
    - In addition, build on existing media campaigns such as RIDE Project AWARE's Let It Out.
- Earned media
    - Radio stations/shows – existing
    - Local newspapers
- In person – community events including health fairs, walks, rallies, back to school events, etc.
- Door to Door Canvassing

OUTCOMES, METRICS, AND MILESTONES:

- Number of organizations we send information to
- Number of organizations that engage and ask for more info
- Number of champions we recruit, and the number who are willing to commit to sharing information with their constituencies
- Collect referral sources at point of contact e.g. "How did you hear about…?"
- Collect data on demographics of system users, including gender, sexual identity, race, ethnicity, zip, etc.

- Baseline of number of children in treatment prior to the outreach blitz, including Emergency Department use for behavioral health crises, including data on suicides, trauma, eating disorders, etc., plus qualitative data from surveys such as the Youth Risk Behavior Surveillance System.

DATA SOURCES:

Social media and other media tracking
Staff tracked metrics
Survey and focus group data

FLAG: MOST IMPORTANT PLANNING ALIGNMENTS

The Outreach and Education Team will need to connect with all of the project work groups for input and to help share information to Work Group members.

BARRIERS AND CHALLENGES:

- Literacy – adult basic education
- Language access
- People's past experience with the system (Community biases)
- Parents with disabilities – cognitive, lack of education, etc.
- Parents with their own health issues (MH, addiction, SU)
- Transportation
- Lack of resources – no telephone, computer
- Cultural beliefs around mental health and behavioral health
- Lack of community support/buy in

TIMELINE CONSIDERATIONS:

- Focus group work should start immediately, to support initial planning
- Champion recruitment should also start very soon, to build support and get more community input
- Communication planning can start within 4 to 6 months, but communication activities must wait until the system is ready
- Must be aware of the 988 communications timeline. There will be national communication about the 988 number within SFY 22, but local communications will wait until SFY 23.

RECOMMENDED ALIGNMENTS WITH OTHER PLANNING PROCESSES

- 988 Work Group
- Mobile Crisis Task Force

Connector Components

Activity #1: Promoting an Effective Single Point of Access, with No Wrong Door

GOAL:

The goal of the Single Point of Access is to provide a more organized pathway to services and supports, within Rhode Island's ultimate strategy to develop and easy and streamlined way for children and their families to access the behavioral health service system regardless of a family's financial resources or insurance status. In addition, Rhode Island's goal will be to ensure that there are no "wrong doors" so that children and families can enter the system through any point – through referrals from schools, primary care physicians, or community programs that will all know how to identify and refer a child.

Rhode Island will move towards a System of Care in which access to services will be delinked from system involvement, insurance status, geographic location, and other factors, resulting in access to the system care by all children and their families based on their needs. However, this is a complex undertaking with the presence of multiple payers in the behavioral health arena, each with different eligibility criteria, enrollment processes, service arrays, and reimbursement strategies. Many state systems of care implementations have structure staged roll outs, in which the system expands as system capacity develops. Rhode Island will initially focus on the development of a Single Point of Access for behavioral health crisis for children and youth and then expand out to more general services.

Key Objective: The passage of the federal National Suicide Hotline Designation Act requires that by July 16, 2022, all states make "988" the universal number for behavioral health emergencies. The Single Point of Access for behavioral health crisis for children and youth will need to be integrated and aligned within Rhode Island's 988 system.

CURRENT SYSTEM DESCRIPTION:

Kids' Link RI is a 24/7 pediatric behavioral health triage and referral hotline operated by Lifespan and has been in existence since 2009. At the beginning of the COVID-19 pandemic, Governor Raimondo's office worked with Kids' Link RI to transition into a central referral hub for children's behavioral health referrals for the state during the crisis. Kids' Link RI implemented Unite Us software [uniteus.com], which offers patient-centered coordination and electronic referral management software in order to begin to build a coordinated care network of health and social service providers for children and youth in Rhode Island.

MAJOR ACTIVITIES AND PRIMARY AUDIENCE:

Rhode Island will focus first on ensuring a Single Point of Access for behavioral health crisis for all children and youth in the state. All activities will need to be aligned with the passage of the federal National Suicide Hotline Designation Act requires that by July 16, 2022, all states make "988" the universal number for behavioral health emergencies.

SERVICES:

A 365/24/7 behavioral health triage and referral hotline for children and youth experiencing a behavioral health crisis with access to a trained counselor by call, text, and chat.

OUTCOMES, METRICS, AND MILESTONES:

- Services implemented in timely manner
- Family satisfaction with the services.
- Increase number of providers offering services
- Improve distribution throughout state
- Reduction in use of higher levels of care due to upstream approach
- Reduction in number of ED visits and repeat visits
- Reduction in overall system costs
- Reduction health disparities in race, language, and physical ability

DATA SOURCES:

- Baseline need assessment with KidsLink volume
- Kids Link average handle time
- Behavioral health-related visits to the ED, urgent care, and IP
- Other diagnoses for behavioral health crises
- DCYF hotline calls for child behavioral health support
- ED visits diverted to Mobile Crisis

FLAG: MOST IMPORTANT PLANNING ALIGNMENTS

The Work Groups that this Activity must align with most are the Workforce and Service Array Work Groups, along with school-based requirements of the of the Nathan Bruno Jason Flatts Act including suicide prevention, intervention and postvention.

BARRIERS AND CHALLENGES:

- Unless services are enhanced, a Single Point of Access is likely to lead to an increase in demand for services from an already overburdened system, resulting in children being referred to longer wait lists rather than effective services. During the initial states of the development of a System of Care, there is a legitimate tension between the goal of working towards an “open” system and that of increasing access so that the system is not overwhelmed, with mounting waiting lists and discouraged families as a result.
- There are gaps in services, including child psychiatry, outpatient services, intensive in-home services, adolescent residential SUD, and linguistic and culturally competent workers and resources.

- There are multiple payers in the children's behavioral health, each with differing eligibility criteria, enrollment procedures, and reimbursement. The current behavioral health system is one in which the availability of services is often linked to a child's system involvement (e.g., child welfare, juvenile justice,) or their insurance status (e.g., Medicaid, commercial insurance, uninsured).
- Need to expand the use of technology such as Unite Us' Community Referral Platform. Rhode Island has procured the Community Referral Platform from Unite Us, to facilitate social services referrals from health care providers to community-based organizations (CBOs). This same system can later be used for e-referrals from state agencies to community agencies and thus, this project would integrate Unite Us with the appropriate state systems, such as DCYF's RICHEST or RIDOC's social service team

POLICY CHANGES REQUIRED:

- None

TIMELINE CONSIDERATIONS:

- Implementation of 988 (July 1, 2022)

RECOMMENDED ALIGNMENTS WITH OTHER PLANNING PROCESSES

- Statewide Mobile Crisis Planning

Activity #2: Data Systems for Outcome Measurement and Evaluation

GOAL:

Develop a set of holistic, child-, family- and system-focused metrics to track, evaluate, and adapt the System of Care. Develop and facilitate a process for integrating the insights into our collective body of work on a regular basis.

CURRENT SYSTEM DESCRIPTION:

Right now, we rely on mostly claims-based or downstream event data. These data tell us how many services and diagnoses kids received, but not about the kids who needed help but never received it; the kids who received support but not from the medical system; how kids, families, and providers, experience the system; or how adequate our capacity – in both quantity and quality – is to meet our kids' needs. There is no holistic process for our state and providers to understand, review and learn from these data and there are few opportunities to see the system as a whole – including where we are underserving kids.

MAJOR ACTIVITIES AND PRIMARY AUDIENCE:

We propose to:

- With the communities we intend to support and serve: define a set of process and outcome metrics that reflect the full system of care from prevention to outcomes. These metrics will ensure we use a race-explicit lens by reporting results by race and ethnicity and underscoring the role that systemic racism, not race alone, plays in disparate outcomes. The metrics will also highlight the need for system integration and effective handoffs – for therapy to be offered in school; for the medical providers to interact with school-based support staff; for single points of access to effectively triage and route and follow up with service connections.
- Define a process for collecting and reporting these necessary data, which will depend on funding levels as some data elements may require new data sources
- Define a process for analyzing data for insights, reviewing with state leaders and community, and integrating insights into continuous program improvement.

OUTCOMES, METRICS, AND MILESTONES:

The data system will include all metrics identified in each of the program components, the foundational components, and the connector components described above. Importantly, we will work with our community partners to ensure that a race-explicit lens is appropriately applied to all metrics tracked including outcome metrics and process metrics.

DATA SOURCES:

All data sources listed above along with the following existing sources:

- All Payer Claims Database
- Data Ecosystem

- DCYF's Rhode Island Family Information System
- DCYF's Rhode Island Children's Information System
- Kids Link

A comprehensive data system will also include new sources including the following:

- Mobile Crisis vendor data
- 988 vendor data
- Single Point of Access vendor data
- Family satisfaction survey data

FLAG: MOST IMPORTANT PLANNING ALIGNMENTS

The Data Team will align with all of the other Work Groups in helping them prioritize metrics.

BARRIERS AND CHALLENGES:

- Adequate staffing – currently planned to be 2 FTE – to establish and maintain a data system for outcome measurement and ongoing evaluation.
- Recent, reliable, and valid race and ethnicity data collection from existing and future data sources.

TIMELINE CONSIDERATIONS:

Timeline on data collection and evaluation is contingent on the timeline of the programs described above and on funding.

Draft Timeline

	FY22 Q2 (Oct - Dec '21)	FY22 Q3 (Jan - Mar '22)	FY22 Q4 (Apr - Jun '22)	FY23 Q1 (Jul - Sep '22)	FY23 Q2 (Oct - Dec '22)
Planning	Pursue community partner comment on the System of Care Plan and make revisions. Continue planning Work Groups and move into implementation planning.	Continue Work Groups for ongoing implementation and evaluation. →	→	→	→
Budget	Complete proposals for FY23 and federal grant	Track budgeting process and pursue additional federal grants	Track budgeting process	Begin process for FY24	Complete proposals for FY24
Implementation/ Procurement	Pursue implementation/ procurement of initial projects as funding becomes available. The first four priorities for implementation are: 1) Mobile Response & Stabilization Services 2) Intensive Home & Community Based Services 3) Care Coordination 4) Prevention Programming	→	→	→	→

Ongoing Outreach/ Community Partner Engagement	As above, pursue community partner comment on the Plan. Kick off Champion Recruitment for plan promotion, focusing on family engagement, ensuring a diverse set of partners. Plan family focus groups.	Continue Champion Recruitment for plan promotion. Kick off Champion Training. Begin family focus groups as a part of ongoing planning and evaluation.	Continue Champion Engagement. Review family focus groups for program adaptations. →	→	→
Hiring	As budget are allocated, post for key staffing positions (Project Management and Family Engagement).	Continue hiring process, as necessary.	→	→	
Policy Changes	Determine what policy changes may be necessary and work with the Governor's Office and others to pursue legislative or regulatory changes.	Track policy changes through the legislative session.	Begin to implement policy changes if passed. →	→	→
Data & Evaluation	Evaluation planning – confirm metrics for tracking program outcomes	Begin to track metrics, as programs being. Start ongoing evaluation reviews.	Continue tracking metrics and evaluation reviews →	→	→

Funding & Sustainability - To Be Completed

As noted above, EOHHS is working with the McKee Administration to complete budget requests for Fiscal Year 2023 and beyond, including proposals for federal American Rescue Plan and Home and Community-Based Services funding. EOHHS is in the process of creating a full Funding and Sustainability Plan and will add the specific budget numbers into the document when they are publicly available.

Potential funding sources include:

- American Rescue Plan Act dollars, including Home and Community Based Services dollars
- Commercial Insurance Coverage
- Medicaid, including potential 85/15 Federal match for Mobile Crisis Services
- Other Federal Grants
- SAMHSA Block Grants
- State General Revenue

Governance

To manage the Rhode Island Behavioral Health for Children, Youth, and Family System of Care, the state will continue and strengthen the groups that it has established for this planning process. The state will:

1) Enhance our interagency structure for ongoing strategic collaboration across multiple state child-serving agencies.
    a. Ensuring alignment within the EOHHS Health Cabinet and Directors' meetings, including RIDE's and OHIC's Commissioner, as appropriate
    b. Ensure that information rises up to the Children's Cabinet
    c. Implement clear focal points of management and accountability to improve oversight of the System of Care at the state level, aligning the work of multiple grant programs with formal interagency MOUs wherever necessary
    d. As projects get funded with state staff as Project or Contract Managers, create a formal work team of these staffers, to ensure ongoing alignment
2) Develop a formal public/private Advisory Committee that will sit on top of the existing Work Group structure.
    a. The Advisory Committee will include community partners and family participants, to carry out additional SOC planning, formal evaluations, and ongoing input into all areas of strategic system development
    b. Work Groups will continue to meet, and will be adapted as necessary

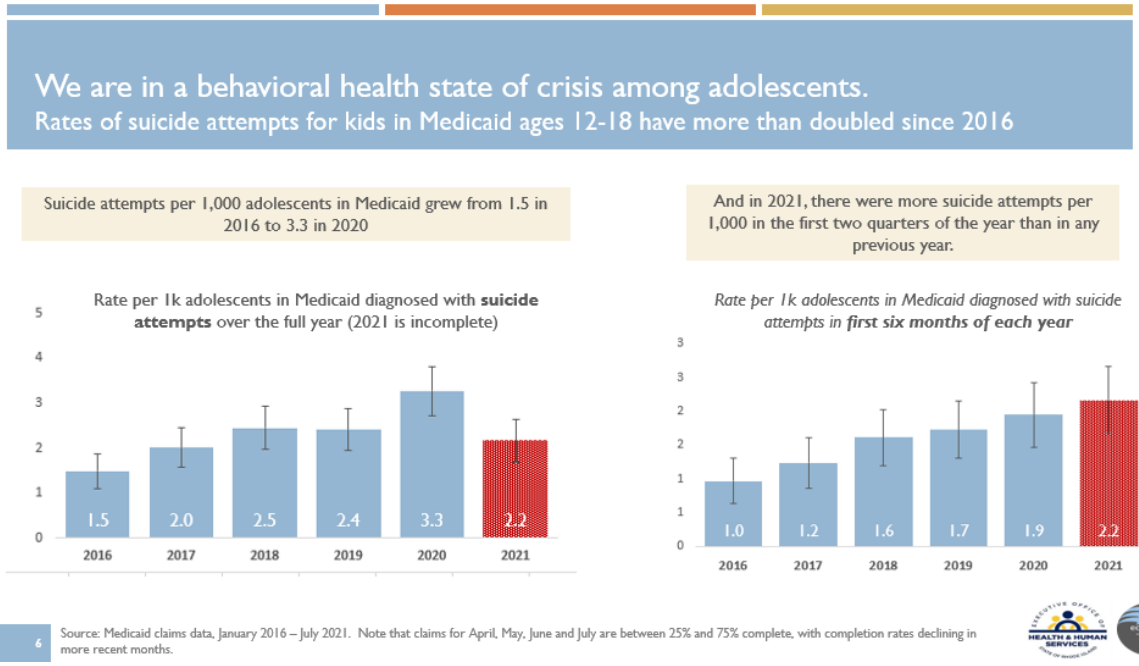
APPENDICES:

Appendix 1: Additional Data

Supplemental figures below are from the State Data Ecosystem analysis that examines data from the Medicaid claims database that had the most recently available data. We display data below through June and July 2021, acknowledging that claims lag is substantial particularly for April through July 2021 data. Despite the lag in claims, we see a number of concerning trends across our adolescent population.

In the three figures below, we see a steady climb in the rate of adolescent suicide attempts, the number of suicide attempts, and the number and rate of suicidal ideation diagnoses for our adolescent Medicaid population.

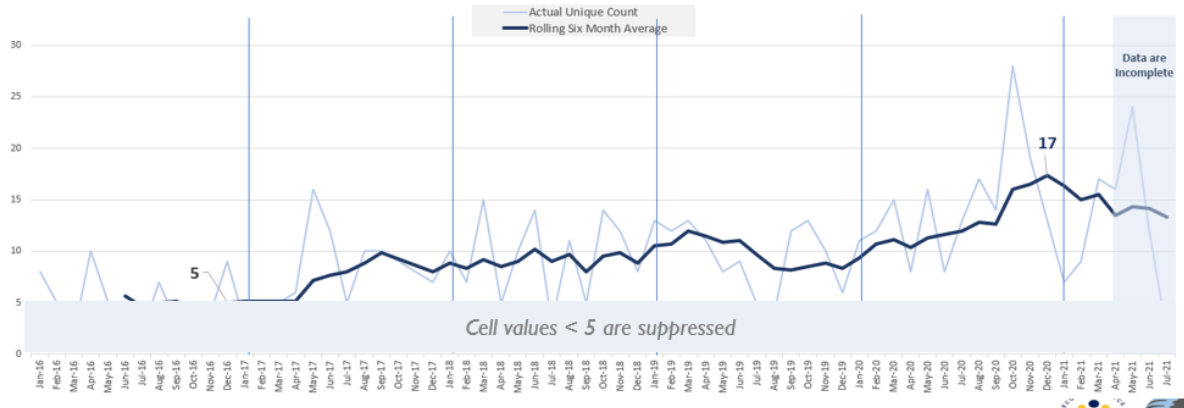
Figure 1.1, 1.2, and 1.3: Adolescent Suicide Attempts and Ideation by Rate and Number



The number of suicide attempts by month has steadily grown since 2016 – and increased rapidly during the pandemic

October 2020: 28 suicide attempts. Note that April, May, and June data are only 25-70% complete.

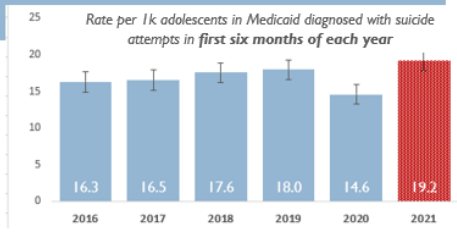
Unique number of adolescents in Medicaid diagnosed with **suicide attempt** each month, with six month rolling average



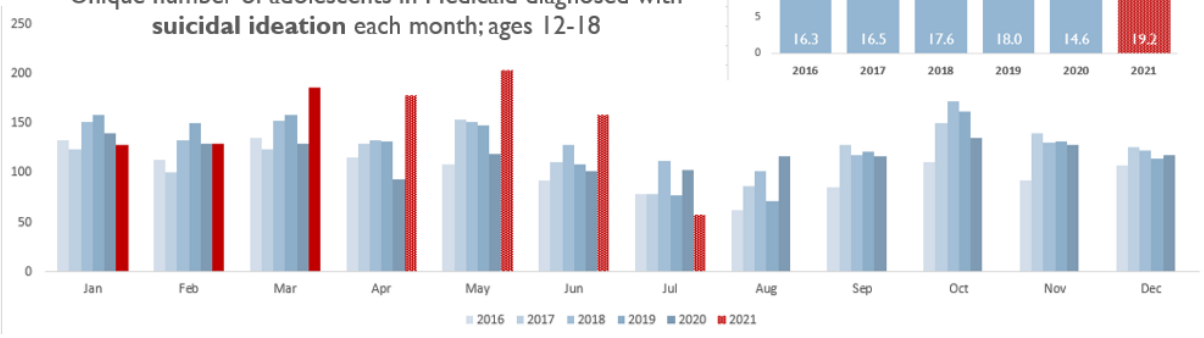
7 Source: Medicaid claims data, January 2016 – July 2021. Note that claims for April, May, June and July are between 25% and 75% complete, with completion rates declining in more recent months.

Suicidal **ideation** has started to spike in Q2 2021 (more than half of the data still missing from these months)

*Rate per 1k adolescents in Medicaid diagnosed with suicide attempts in **first six months of each year***



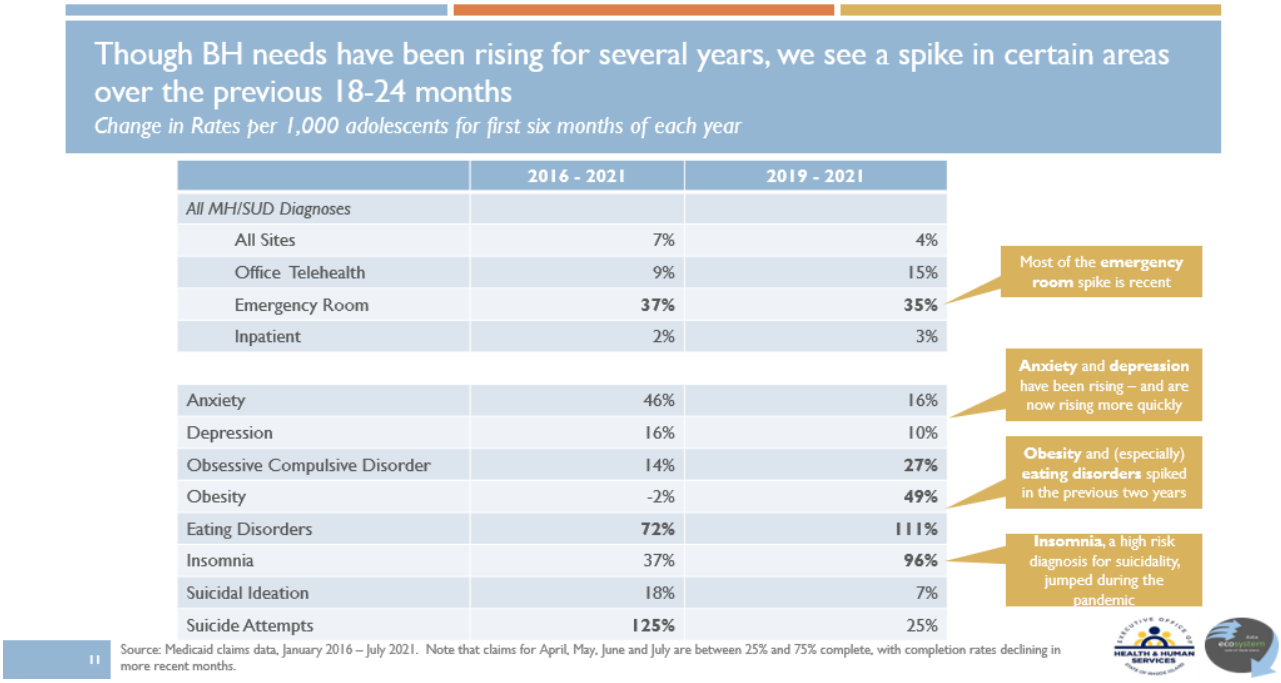
Unique number of adolescents in Medicaid diagnosed with **suicidal ideation** each month; ages 12-18



9 Source: Medicaid claims data, January 2016 – July 2021. Note that claims for April, May, June and July are between 25% and 75% complete, with completion rates declining in more recent months.

Suicidality is a tragic manifestation of the much bigger, broader, rapidly growing behavioral health need among adolescents that began before the pandemic and has worsened since. The slide below shows the 5-year change (2016-2021) in the first column and the most recent two-year change (2019-2021) to highlight the role the pandemic period has played in an already growing behavioral health crisis.

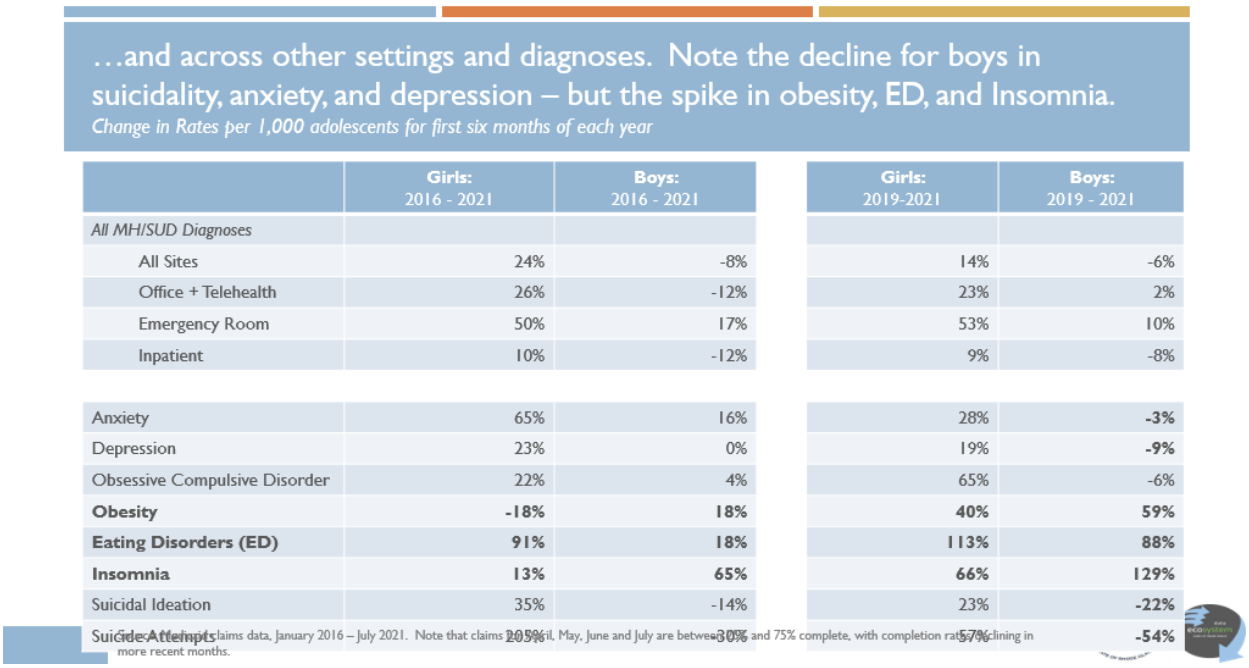
Figure 1.4: Longitudinal Youth Behavioral Health Diagnoses



	2016 - 2021	2019 - 2021
All MH/SUD Diagnoses		
All Sites	7%	4%
Office Telehealth	9%	15%
Emergency Room	**37%**	**35%**
Inpatient	2%	3%
Anxiety	46%	16%
Depression	16%	10%
Obsessive Compulsive Disorder	14%	**27%**
Obesity	-2%	**49%**
Eating Disorders	**72%**	**111%**
Insomnia	37%	**96%**
Suicidal Ideation	18%	7%
Suicide Attempts	**125%**	25%

Gender Disparities in our Behavioral Health Crisis As noted in the narrative above, rates for these diagnoses are different for boys and young men versus girls and young women. We actually observe declining rates of suicidality in the most recent years. While there are disparities among the genders, boys and young men are overrepresented in the most tragic outcome: completed suicides. Using regional data, we know that 78% of completed suicides among those age 15-24 in the Northeast between 2016 and 2019 were male.

Figure 1.5: Longitudinal Youth Behavioral Health Diagnoses by Gender



…and across other settings and diagnoses. Note the decline for boys in suicidality, anxiety, and depression – but the spike in obesity, ED, and Insomnia.

Change in Rates per 1,000 adolescents for first six months of each year

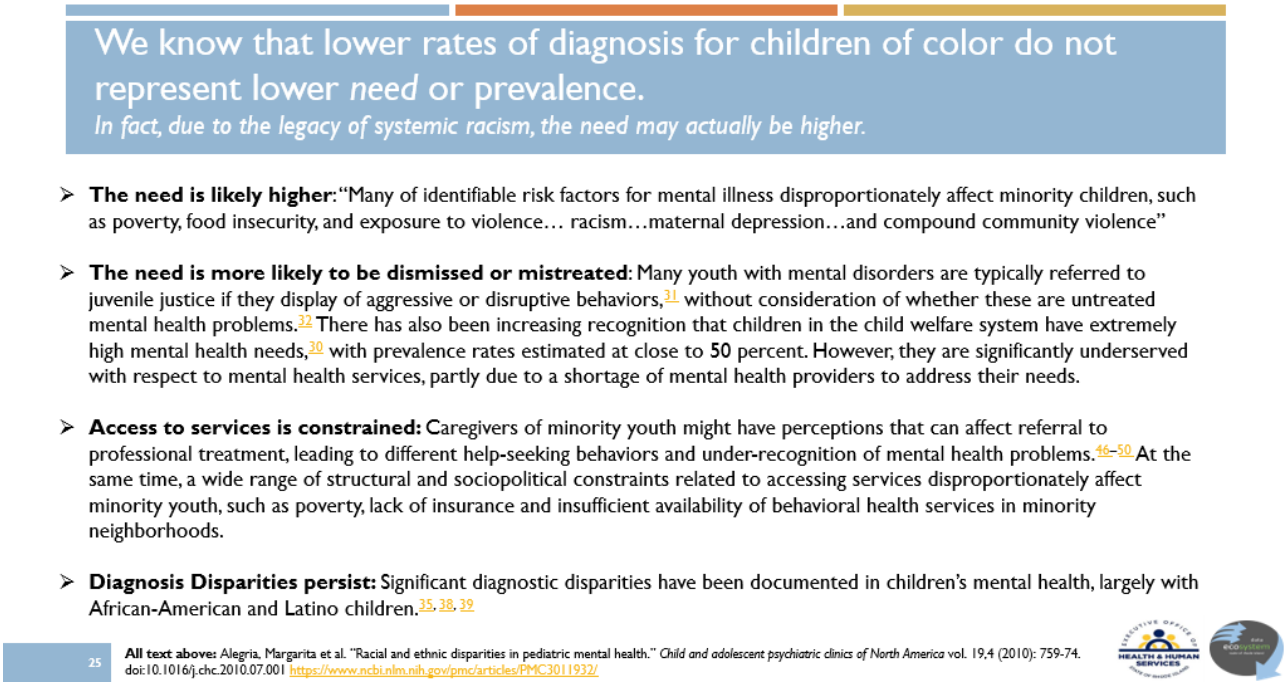
	Girls: 2016 - 2021	Boys: 2016 - 2021	Girls: 2019-2021	Boys: 2019 - 2021
All MH/SUD Diagnoses				
All Sites	24%	-8%	14%	-6%
Office + Telehealth	26%	-12%	23%	2%
Emergency Room	50%	17%	53%	10%
Inpatient	10%	-12%	9%	-8%
Anxiety	65%	16%	28%	**-3%**
Depression	23%	0%	19%	**-9%**
Obsessive Compulsive Disorder	22%	4%	65%	-6%
Obesity	**-18%**	**18%**	**40%**	**59%**
Eating Disorders (ED)	**91%**	**18%**	**113%**	**88%**
Insomnia	**13%**	**65%**	**66%**	**129%**
Suicidal Ideation	35%	-14%	23%	**-22%**
Suicide Attempts	205%	-30%	57%	**-54%**

Source: Optum claims data, January 2016 – July 2021. Note that claims data for April, May, June and July are between 50% and 75% complete, with completion rates declining in more recent months.

Using a Race Equity Lens: Racial and Ethnic Disparities in our Behavioral Health System

The data show lower rates of diagnosis for children of color – but this masks the need, which, because of the legacy of structural racism, is likely *higher* than for children who identify as White or Non-Hispanic:

Figure 1.6: Youth Behavioral Health Diagnoses by Race and Ethnicity



Using a race equity lens to analyze these data is urgent: if we just look at the numbers of children who receive a diagnosis, or a visit to a clinician, we may believe that we are serving our children of color adequately, or that the need is less.

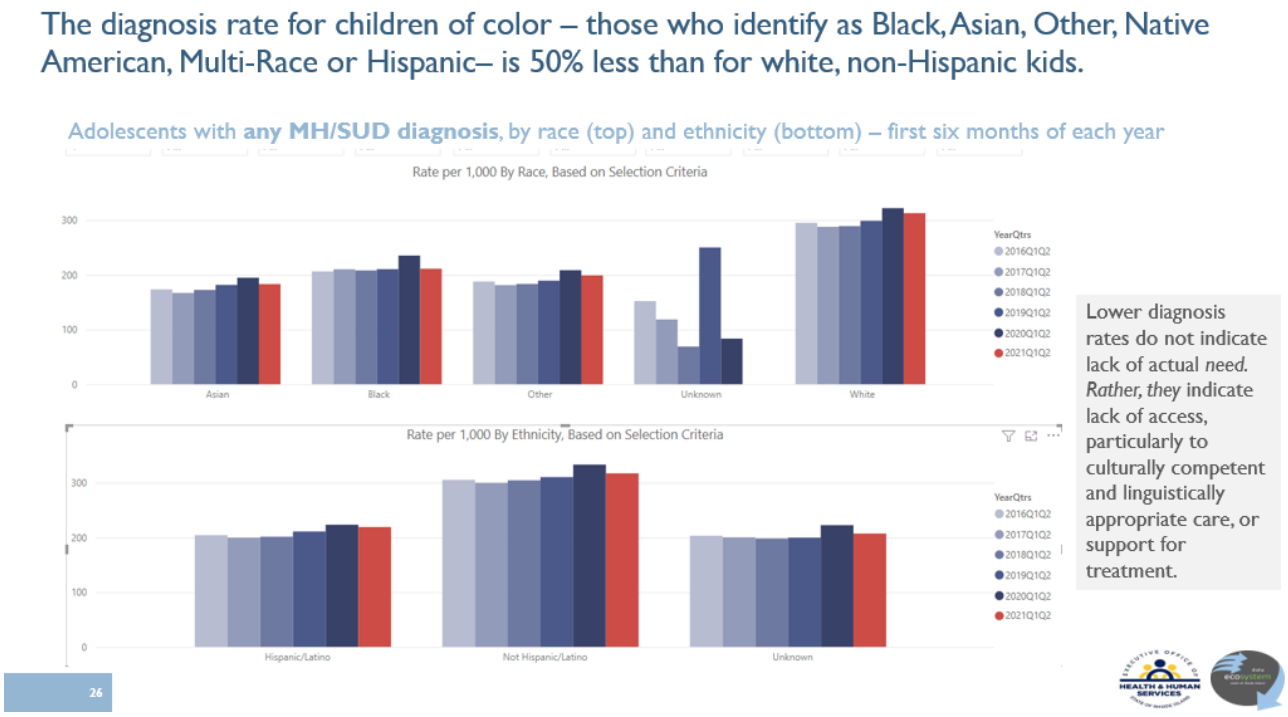
But the data show that the gap in diagnosis rates closes as the behavioral health needs moves from chronic to acute – meaning, children of color are much less likely to be treated for anxiety and depression, but there is almost no gap between white and Black adolescents in the rate of suicide attempts.

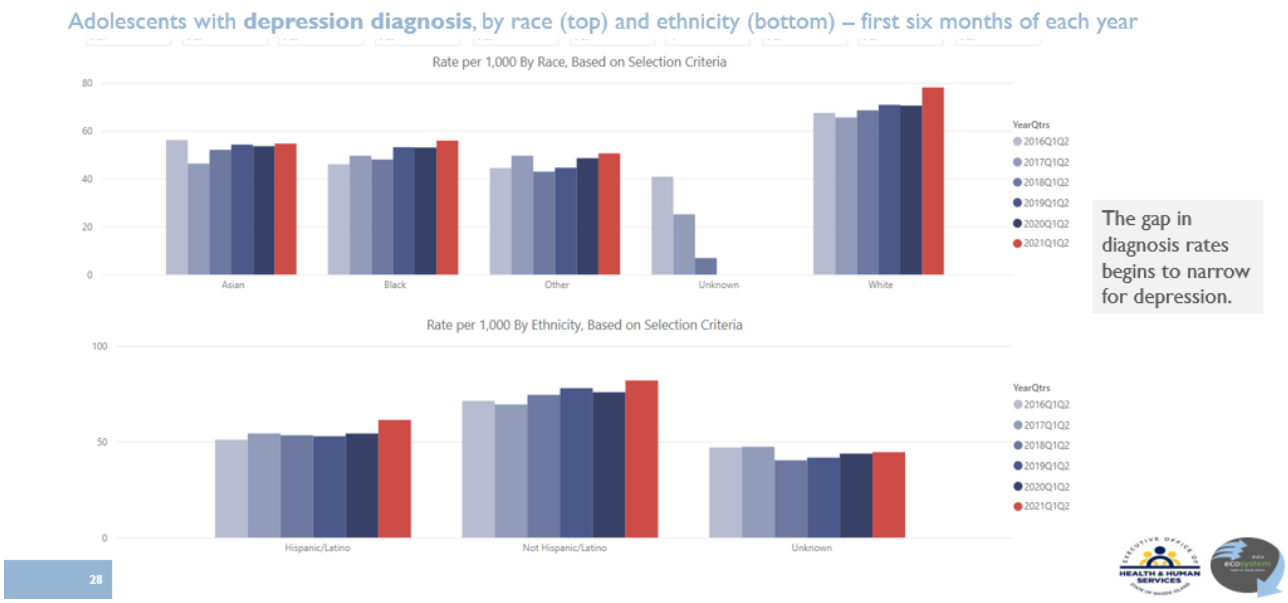
Similar to how the absence of boys among those who receive anxiety and depression diagnosis – particularly in office-based diagnosis settings – indicates more lack of access and lack of society understanding and support than true differences in *need,* these data give evidence that there are not safe, supported onramps for children of color. The care our children of color receive is more likely to be emergency-based and reactive, and at the intersection of race and gender, this is doubly true for boys of color who we see overrepresented in the criminal justice and child welfare system.

Placing children of color into the juvenile justice or child welfare system - *or no system at all* – rather than ensuring that they can receive quality, culturally, and linguistically competent

treatment is a clear example of the systemic racism of our overall system of care. We must acknowledge this openly and work to eliminate the disparities and implicit bias that sets up this discrimination.

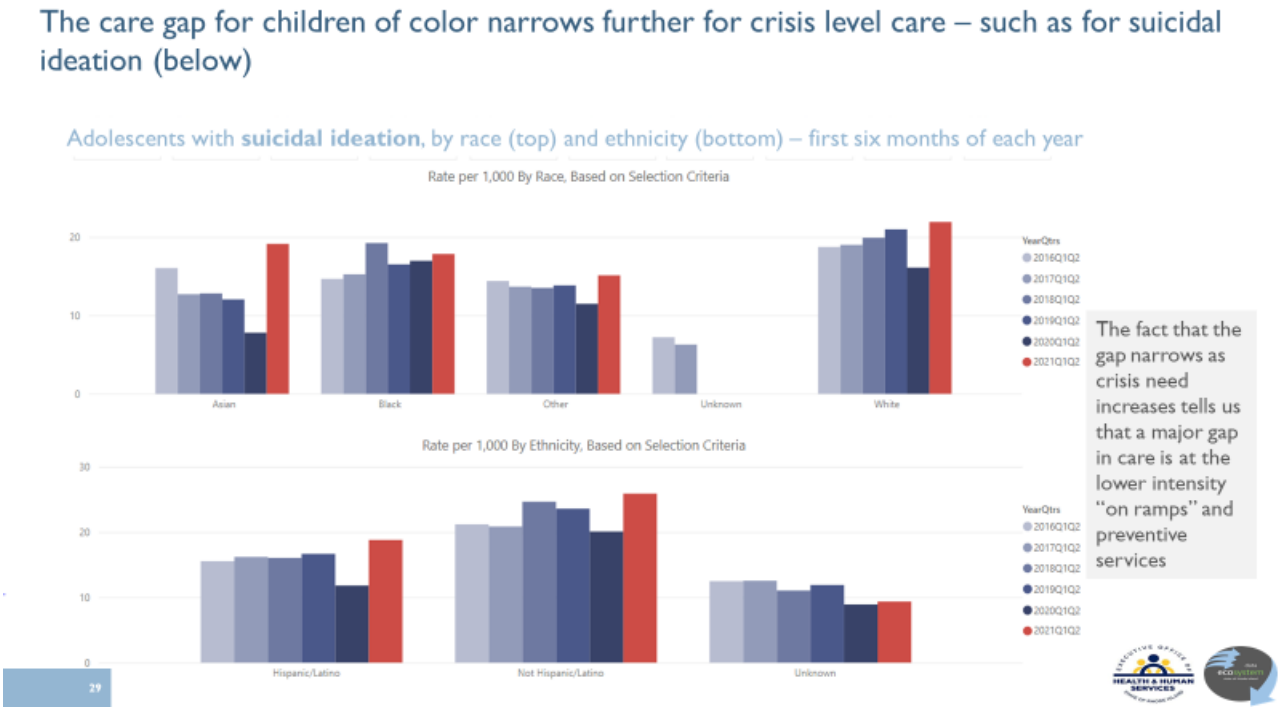
Figures 1.7 and 1.8: Racial and Ethnic Disparities in Youth Behavioral Health Diagnoses

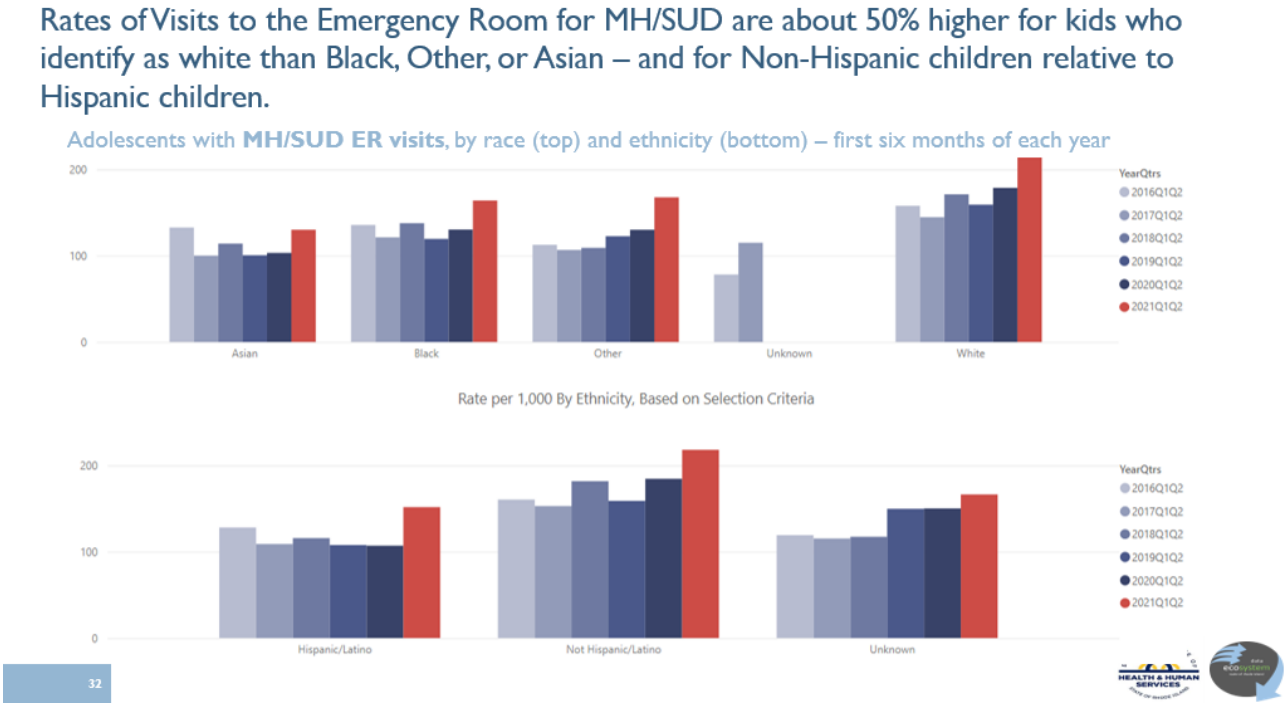




Community partners have shared the great need for more crisis services, which we explore throughout this plan, but we must plan those services with a deep awareness of the specific needs of our children and families of color:

Figures 1.9 and 1.10: Racial and Ethnic Disparities in Care and Emergency Room Visit Rates





Appendix 2: Workgroup Participants

1. Crisis continuum, development and access, screening, and assessment
    a. Meeting participants: Margaret H McDuff's (CEO FSRI), Shannon Ciccone (Clinical Director of the ABA EIBI Program at Perspectives Corporation), Kyle Edward, (NHPRI Neighborhood Health Plan Behavioral Health Department), Joe Robitaille - Trudeau Center (Trudeau Center VP of Children's Services), Barbara Lamoureux (Vice President of Youth and Family Services Thrive Behavioral Health), Ashlee Gray (Northeast Family Services), Sarah Kelly-Palmer (Family Service of Rhode Island), Susan Jewel (The Autism Project), Jenna Chaplin (Tides Family Services), Kayla David (LMFT Clinical Director Family Service of Rhode Island), Jessica Waugh (Groden CHTS Clinical Director), Rena Sheehan (Vice President Clinical Integration BCBSRI) Kathleen Donise, MD (Director for Lifespan's pedi behavioral health emergency service), Jessica Walsh (LICSW Manager of Integrated Care Management at NHPRI), Carolyn Souza (Clinical Director - Looking Upwards), Marcia Tryon (Newport Mental Health- Manager of Children and Adolescent Services), Laura Scussel (Thrive Behavioral Health), Colleen Judge (Director, School Based Services, RI Student Assistance Services), James Simon (LICSW Senior Director of Deaf & Hard of Hearing Services with Perspectives Corporation), Cindy M. Gordon (LICSW Newport Mental Health-Chief Clinical Officer), Fred Barbosa (LICSW; Administrative Director C&F), Catherine Hunter (BHDDH Admin of Program Mgmt Newly appointed BH Link contract manager), James DiNunzio (NHPRI), Naiommy Baret (Statewide Family Leadership Coordinator and Behavioral health Education Coordinator), Beth Bixby (Tides Family Services), Sarah Sparhawk (Chief Implementation Aide, Children's Services and Behavioral Health, DCYF).
2. Care authorization, care coordination and care monitoring
    a. Maayan Rosenfield, Chris Strnad, Maria Terrero Kamara, Becky Almeida (parent), Kelci Conti, Marie Palumbo-Hayes, Jessica Walsh (BCBSRI), Laura Scussel, Robert LaRocco, N. Hermiz, Sarah, Robert Archer, Tanja Kubas-Meyer, Susan Lindberg (DCYF), Sandra Peltier, Jamie DiNunzio, Sarah Fleury
3. Service array
    a. Rosemary Reilly-Chammat (RIDE) Carlene Casciano-McCann (St. Mary's Home for Children), Jennifer Levy (RIDOH), Sue Bruce (Optum with United Healthcare Medicaid), Joe Robitaille (VP Children's Services Trudeau Center), Rosaly Cuevas (BCBSRI), Kyle Edward (Kyle Edward Neighborhood Health Plan of RI), Valentina Laprade (VP of Programs, Children's Friend), Nidhi Turner (Northeast Family Services), Sandy Peltier (Director HBCS Trudeau Center), Rebecca Silver (Bradley Hospital Early Childhood Collaborative), Gabriel Soden (Child & Family), Charlotte Kreger (EOHHS), Melissa Ross-Clinical Director (Ocean State Behavioral), Kelci Conti Clinical (Director of Behavioral Health CCAP), Seena Franklin (VP of Program Development for CCAP), Tara Hayes (RI Parent Information Network (RIPIN)), Jenna Nelson (Family Service of RI), Ashlee Gray (Northeast Family Services), Joe Carr

(LICSW DCYF Early Childhood Resource Specialist), Jason Lanzillo (Director of Children Services The Frank Olean Center), Cheryl Dill (LMFT from Family Service of Rhode Island - Director of Community Service), Denise Achin (BHDDH)

4. Ensuring equity: race equity, family members, with IDD, and LGBTQ+ Families
    a. Marti Rosenberg (EOHHS), Samantha Brinz (RIDE), Jesse Hunter (CPNRI), Tina Spears (CPNRI), Danielle Loughlin (Perspectives Corporation), Melissa Santoro (St. Mary's Home for the Children), Ruth Tureckova (Frank Olean Center), Veronica Bourget (PSNRI), Maria Terrero-Kamara (DCYF), Charlotte Kreger (EOHHS), Jordan Maddox (BHDDH), James Rajotte (EOHHS), Jenny Bautista (BCBSRI), James Simon (Perspectives Corporation), Susan Duffy (Hasbro Children's Hospital), Susan Hayward (BHDDH), Kayla David (FSRI), Trisha Suggs (BHDDH), Danielle Cyprien (PSN), Alyssia Ramos (Groden Center)
5. Workforce transformation
    a. Sarah Kelly Palmer, Maayan Rosenfield, Jason Lanzillo, Rick Brooks (facilitator), Joe Robitaille, Dana Mullen, Marti Rosenberg, Ben Weiner, Jenna Chaplin, Natalie Fleming, Naiommy Baret, Marianne Raimondo, Laura Scussel, Marge Paccioe, Linda Marzilli (PSNRI), Tanja Kubas-Meyer, Veronica Bourget, Carol LaFrance, Rena Sheehan, Ashlee, Colleen Judge, Jesse Hunter, Joanne Savoie, Cheryl Dill, Susan Dickstein, Monique DeRoche, Melissa Melvin, Branda Verdis
6. Data systems for outcomes measurement and evaluation
    a. Alex Hunt (Tides Family Service), Ayelet Kantor (The Groden Network), Ben Weiner (Family Services of RI), Chris Strnad (Department of Children, Youth, and Families), Colleen Caron (Department of Children, Youth, and Families), Dr. Amy Goldberg (Hasbro Children's Hospital and Brown University), Dr. Megan Ranney (Rhode Island Hospital and Brown University), Dr. Pat Flanagan (Hasbro Children's Hospital and Brown University), Emily Corbett (Family Services of RI), Joe Robitaille (Trudeau Center), Liana Gonzales-McGee (Providence Public Schools), Lisa Conlan (Parent Support Network), Naiommy Baret (Parent Support Network), Natalie Fleming (RI Department of Education), Nicole Des Champs (Department of Children, Youth, and Families), Russ Cooney (Neighborhood Health Plan of RI), Suellen Rizzo (St. Mary's Home for Children), Susan Lindberg (Department of Children, Youth, and Families), Tanja Kubas-Meyer (RI Coalition for Children and Families)
7. Community outreach and education
    a. Marti Rosenberg (Facilitator), Ashley O'Shea (Director of Strategic Communications at EOHHS), Amie Ashegh (Stakeholder for families we are supporting in my program), Nicole Saunders (Providence Center for 15 years – clinical director for DCYF programs), Maggie Slane (VP of Advancement Family Service of RI – a provider of care, a coordinator, a partner), Kristin Petrarca (RIDE – federal funding through SAMHSA for Project Aware), Russ Cooney (Neighborhood Health Plan – 40 years – Grandson with Autism), Susan Jewel (Manager of Family Support at Autism Project of RI – I have two young adults daughters with autism), Marcia Tryon (Manager

Newport Mental Health – Service Provider) Jessica Waugh (Groden Center Clinical Director) Denise Achin (Oversee Healthy transitions grant at BHDDH), Ashlee Gray (Oversee homebased services at my agencies) Kelly Brennan (PIO at DCYF), Randy Edgar (PIO at BHDDH), Charlotte Kreger (work on EOHHS on Marti's team, lead for the ensuring equity group), Naiommy Baret (Statewide Family Leadership Coordinator/BH Education Specialist at Parent Support Network RI), Tina Spears (Executive Director of organization that supports adults and children with disabilities), Patricia Holiday (I work with Child and Family Services – VP of HR)

8. Prevention (added in late June)
    a. Maayan Rosenfield (EOHHS), Denise Achin (BHDDH), Blythe Beger (RIDOH), Joseph Carr (DCYF), Annice CorreiaGabel (OHHS), Jeffrey Hill (RIDOH), Susan Lindberg (DCYF), Ana Novais (EOHHS)

Appendix 3: Champion Recruitment Plan

Here is a draft detailed build out of the Champion Recruitment Plan. This will be a living plan, and EOHHS encourages community feedback on others to include in the document.

- Champion Definition: Leaders from community, faith, provider, and other key organizations, as well as policy-makers who are prepared to speak out and connect people to the System of Care plan. Ensure diversity of Champions, including diversity of race, ethnicity, languages spoken, age, gender, sexual orientation, gender identify, ability, socio-economic status, and geography.
- Preparing the Champions
    - Create an elevator pitch for aligned messaging
    - Educating Champions through training, developing a Train the Trainer Curriculum
    - Ensure support for Champions where needed, including gift cards, food for meeting, and transportation assistance for access
    - Ensuring a communications budget
- Creating a Champion Feedback loop
    - Create strategies and tactics to collect what they're hearing
        - For example, creating a shared electronic drive for sharing information back and forth and with the System of Care Governance Structure

Here is a draft list of people who EOHHS will prioritize recruiting as Champions. As noted above, none of these lists are final and the organizational names in each section are in alphabetical order. We welcome input of categories of people and specific proposals of names and contact information:

1) Caregivers – from a variety of populations, including
    a) Families of children being discharged from hospitals (including Bradley),

b) Families speaking languages other than English
c) Families with children with a developmental disability,
d) Families with children with special health care needs,
e) Families with medically fragile children,
f) Foster parents,
g) Latinx families,
h) LGBTQ+ families,

2) Youth, through youth-led organization
   a) Arts organizations
   b) Providence Student Union
   c) Sports leagues
   d) VISTA
   e) Youth Pride

3) Providers of services, or community provider supports
   a) AmeriCorps
   b) Chiropractors, and alternative health practitioners
   c) Community Health Teams
   d) Community Mental Health Centers and other behavioral health organizations
   e) Early intervention
   f) Family Care Community Partnership
   g) First Connections – Family Home Visiting providers
   h) Head Start and Early Head Start
   i) Health Equity Zones
   j) Hospitals and clinics (work on getting information in bags given to families seeking behavioral health care)
   k) Pediatricians and primary care providers
   l) Pharmacies
   m) Providers for Children with Developmental Disabilities, including the Sherlock Center
   n) Regional Prevention Coalitions
   o) Specialists, including OB-GYNs

4) Provider Organizations or programs including providers
   a) Community Provider Network of Rhode Island
   b) Insurance Plans
   c) PediPRN
   d) Rhode Island Coalition for Children and Families

5) Faith Organizations and Faith Leaders
   a) Board of Rabbis

b) Catholic Social Services
c) Jewish Community Center
d) Muslim Organization(s)
e) Rhode Island Catholic Diocese
f) RI Ministerial Alliance
g) RI State Council of Churches

6) Educational Organizations
   a) 21st Century Afterschool Programs
   b) After-School programs
   c) Child Opportunity Zones
   d) Directors of Special Education & School Supports
   e) Early care providers
   f) Family liaisons in schools (Central Falls)
   g) Guidance counselors and school nurses
   h) Parent Advisory Committees (PTAs, PTOs) and the statewide alliance of these committees
   i) Parent- and youth-led advisory groups
   j) School District leadership
   k) School Nurses
   l) School Social Workers
   m) Teachers Unions
   n) Title V programs
   o) Transitional Advisories
   p) Universities
      i) Disability Services, Counseling Centers, Health Services
      ii) Medical School
      iii) Nursing Programs
      iv) Social work programs
      v) Student organizations

7) Community organizations - Specific community programs include:
   a) Boys and Girls Clubs
   b) Center for Southeast Asians
   c) Disability Rights RI
   d) Dorcas International
   e) Higher Ground International
   f) Institute for Study and Practice Nonviolence
   g) Local community/neighborhood organizations
   h) Local interpretation agencies
   i) NAACP
   j) Newport Partnership for Families

k) Parents Leading Educational Equity
l) Red Cross
m) Refugee Dream Center
n) Restorative justice organizations – community groups,
o) Rhode Island for Community and Justice
p) Rhode Island Kids Count
q) RI Coalition Against Domestic Violence – and its member shelters
r) Special Olympics
s) Sports teams/coaches – RI Interscholastic League
t) Strong Black and African American Families program
u) Summer Camps
v) United Way of Rhode Island/211
w) Washington County Coalition for Children (HEZ)
x) YMCAs, with a state alliance

8) Businesses and other Community-Based Settings
   a) Barber shops and hair salons
   b) Bars and clubs – bartenders
   c) Chambers of Commerce
   d) City and town recreation departments
   e) Human Resources Departments (especially in large companies)
   f) Local playgrounds
   g) Residential support people in public housing

9) Justice System
   a) Court system
   b) Legal Aid
   c) Public Defenders Office
   d) Rhode Island Legal Services
   e) Rhode Island Training School

10) First Responders
   a) Emergency Medical Services
   b) Fire Fighters
   c) Police Departments

11) Policy-Maker Champions
   a) State legislators
   b) City and town officials

12) Governmental Administrative Entities

a) Executive Office of Health and Human Services
b) Narragansett Indian Tribe
c) Office of the Health Insurance Commissioner
d) Rhode Island Commerce
e) Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals
f) Rhode Island Department of Children, Youth, and Families
g) Rhode Island Department of Corrections
h) Rhode Island Department of Environmental Management
i) Rhode Island Department of Health
j) Rhode Island Department of Health
k) Rhode Island Department of Human Services

Appendix 4: Acronym List

Rows highlighted in yellow are common terms in the children's system, and rows highlighted in gray are grants program titles.

ACT	Assertive Community Treatment
ASAM	American Society of Addiction Medicine
ASD	Autism Spectrum Disorder
ASU	Adult Stabilization Unit
BHOLD	Behavioral Health Online Data (system)
CBT	Cognitive Behavior Therapy
CCBHC	Certified Community Behavioral Health Clinics
CIT	Crisis Intervention Team
CLAS	Culturally and Linguistically Appropriate Services
CMHC	Community Mental Health Centers
CMHO	Community Mental Health Organization
CMHS	Center for Mental Health Services (at SAMHSA)
COD	Co-occurring Disorder
CPS	Child Protective Services
CSAP	Center for Substance Abuse Prevention (at SAMHSA)
CSAT	Center for Substance Abuse Treatment (at SAMHSA)
CSC	Coordinated Specialty Care
CSHCN	Children with Special Health Care Needs
CSP	Community Support Program
CSS	Community Support Services
CSU	Crisis Stabilization Unit
DBT	Dialectic Behavior Therapy
ED	Early Diversion
EHR	Electronic Health Record
EPSDT	Early Periodic Screening, Diagnosis, and Treatment (Medicaid program)
FCAB	Family Community Advisory Board
FCCP	Family Care Community Partnerships
FEP	First Episode Psychosis
FOP	Forensic Outpatient
GOP	General Outpatient
GPO	Government Project Officer
GPRA	Government Performance and Results Modernization Act
HCBS	Home and Community Based Services
HT	Healthy Transitions
IEP	Individual Education Plan
IHH	Integrated Health Home
IMD	Institute for Mental Disorders (16 beds or more)
IOP	Intensive Outpatient
ISP	Immediate Services Program
LCDP	Licensed Chemical Dependency Professional
LOC	Level of Care
LOS	Length of Stay

MAT	Medication Assisted Treatment
MCRT	Mobile Crisis Response Teams
MHA	Mental Health Association
MI	Motivational Interviewing
MST	Multi-Systemic Therapy
NOA	Notice of Award
NOMS	National Outcome Measures
NREPP	National Registry of Evidence-based and Promising Practices (SAMHSA)
NSDUH	National Survey on Drug Use and Health
OMB	Office of Management and Budget
OSCRH	Ocean State Coalition of Recovery Houses
OTP	Opioid Treatment Program (Methadone)
PASRR	Pre-Admission Screening and Residential Review
PATH	Projects for Assistance in Transition from Homelessness
PFS	Partnership for Success
PHP	Partial Hospitalization Program
PIPBHC	Promoting Integration of Primary and Behavioral Health Care
PRS	Peer Recovery Specialist
PSN	Parent Support Network
RICARES	RI Communities for Addiction Recovery Efforts
RICHIST	RI Children's Information System
RICOC	Rhode Island Continuum of Care (RI Housing)
RIPIN	Rhode Island Parent Information Network
RSP	Regular Services Program
SAIS	*Services Accountability Improvement System* (SAMHSA data system)
SAMHSA	Substance Abuse and Mental Health Services Association
SBIRT	Screening, Brief Intervention and Referral to Treatment
SED	Serious Emotional Disturbance
SEP	Supported Employment Program
SIM	Sequential Intercept Model
SMI	Serious Mental Illness
SOC	System of Care
SOR	State Opioid Response (grant)
SPARS	SAMHSA's Performance Accountability and Reporting System
SPMI	Serious and Persistent Mental Illness
SUMHLC	Substance Use and Mental Health Leadership Council
SYT-I	State Youth Treatment – Implementation
SYT-P	State Youth Treatment – Planning (closed grant)
TAY	Transition Age Youth
TEDS	Treatment Episode Data Set
TRAC	Transformation Accountability System (SAMHSA data system)

Appendix 5: Program Component #1 Detailed Plan: Prevention

Appendix 6: Foundational Component #1 Detailed Plan: Ensuring Equity

References

[i] America's Health Rankings analysis of CDC WONDER Online Database, Underlying Cause of Death, Multiple Cause of Death files, United Health Foundation, AmericasHealthRankings.org, Accessed 2021.
[ii] Children's Bureau/ACYF Systems of Care. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. https://www.childwelfare.gov/pubpdfs/soc.pdf. Accessed 2021.
[iii] Stroul, B.A., Blau, G.M., & Larsen, J. (2021). The Evolution of the System of Care Approach. Baltimore: The Institute for Innovation and Implementation, School of Social Work, University of Maryland.
[iv] Anderson, Scrimshaw, Fullilove, Fielding, Normand J. Culturally competent healthcare systems. Am J Prev Med. 2003;24:68–79
[v] O'Connell, M. E., Boat, T., & Warner, K. E. (2009). Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities. Washington, DC: The National Academies Press; and U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2009). Risk and protective factors for mental, emotional, and behavioral disorders across the life cycle. http://dhss.alaska.gov/dbh/Documents/Prevention/programs/spfsig/pdfs/IOM_Matrix_8%205x11_FINAL.pdf
[vi] SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, 2014. Accessed 2021. https://www.acesaware.org/ace-fundamentals/principles-of-trauma-informed-care/
[vii] SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (2014)
[viii] Alegria, Margarita et al. "Racial and ethnic disparities in pediatric mental health." *Child and adolescent psychiatric clinics of North America* vol. 19,4 (2010): 759-74. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3011932/
[ix] Maria Trent, Danielle G. Dooley, Jacqueline Dougé, SECTION ON ADOLESCENT HEALTH, COUNCIL ON COMMUNITY PEDIATRICS and COMMITTEE ON ADOLESCENCE Pediatrics August 2019, 144 (2) e20191765; DOI: https://doi.org/10.1542/peds.2019-1765.
[x] Schupmann, W. (2017, October 26). How Housing Quality Affects Child Mental Health. Housing Matters an Urban Institute Initiative. https://housingmatters.urban.org/articles/how-housing-quality-affects-child-mental-health
[xi] The Economic Progress Institute, Women's Fund. THE UNEVEN PATH 2020: State Investments in Women's Economic Security. 2020, https://www.economicprogressri.org/wp-content/uploads/2020/01/Uneven-Path-Executive-Summary-FINAL-WEB.pdf.
[xii] ECONOMIC PROGRESS REPORT June 2019. Economic Progress Institute. Accessed 2021. http://www.economicprogressri.org/wp-content/uploads/2019/06/FINAL-Improving-Access-and-Quality-RI-CCAP.pdf
[xiii] Mental Health America, Inc. "LGBTQ+ Communities and Mental Health." Mental Health America, 2021, https://www.mhanational.org/issues/lgbtq-communities-and-mental-health.
[xiv] Jones, Jeffrey M. "LGBT Identification Rises to 5.6% in Latest U.S. Estimate." Gallup.com, Gallup, 13 Aug. 2021, https://news.gallup.com/poll/329708/lgbt-identification-rises-latest-estimate.aspx.
[xv] CDC. "Disability Impacts All of Us Infographic." Centers for Disease Control and Prevention, 16 Sept. 2020, https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html.
[xvi] CDC. "Many Adults with Disabilities Report Frequent Mental Distress." Centers for Disease Control and Prevention, 10 Sept. 2020, https://www.cdc.gov/ncbddd/disabilityandhealth/features/adults-with-disabilities-mental-distress.html.