Rhode Island Statewide Community Needs Assessment:

Certified Community Behavioral Health Clinic Planning

March 2024

Acknowledgements

The evaluation team would like to acknowledge and thank the many organizations and their staff who supported this assessment and helped ensure that it included the valuable insights of staff working directly in the community. Most importantly, we would like to thank and acknowledge our great appreciation of individuals who volunteered to speak with us about their lived and living experiences and enduring challenges.

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Executive Summary

The Substance Abuse and Mental Health Services Administration (SAMHSA) requires that organizations seeking to become Certified Community Behavioral Health Clinics (CCBHCs) conduct a community needs assessment (CNA) for their region. This assessment helps shape a wide range of CCBHC elements, including staffing, training, hours, locations, range of services, and community partnerships. This CNA focuses on Rhode Island overall and was completed through a partnership between the state's aspiring CCBHCs, potential Designated Collaborating Organizations (DCOs), and an outside organization that assisted with data collection and analysis.

CCBHC Model Background

The CCBHC model represents a new approach to delivering community behavioral health services, with a particular focus on individuals experiencing serious mental illness (SMI), substance use disorder (SUD), serious emotional disturbance (SED), co-occurring disorders, and/or a behavioral health crisis. Because CCBHC requirements represent a significant expansion of outreach, engagement, support, and services, CCBHCs may lack the capacity and/or expertise to provide accessible, high-quality services for the full population targeted by the model. Many therefore develop contracts with DCOs to provide portions of the required services. This allows the CCBHC to become the heart of a complex hub-and-spoke model for behavioral health services and build on high-quality services already provided by other local organizations.

One of the key roles of the CNA is to support CCBHCs in developing their hub-and-spoke model in a way that takes advantage of local partnership opportunities and addresses regional needs. The CNA also helps shape CCBHCs' staffing and training plans and a variety of other program considerations. The assessment focuses on the needs of the five CCBHC target populations in the organization's community, with a particular emphasis on individuals not currently engaged. Ultimately, the goal of the CNA is to provide data that will assist in developing strategies to reach and ensure continued engagement of each of the CCBHC priority populations.

Rhode Island CCBHC Regions

Rhode Island has eight CCBHC regions, which vary substantially in terms of their populations, social and economic characteristics, and behavioral health landscapes. This variation is discussed in detail in the main body of this report and gives rise to a diversity of needs across the state.

Methodology

This needs assessment uses a mixed-methods (quantitative and qualitative) triangulation methodology that incorporates existing reports and white papers, secondary data, and primary data. The evaluation team worked with each CCBHC and DCO to complete CNA activities in each region. In addition, the CNA uses a conceptual framework based on Benfer's Health Justice framework and the World Health Organization (WHO)'s Conceptual Framework for Action on the Social Determinants of Health to diminish inherent bias and enable evaluators and readers to view assessments through a wider perspective than their personal experience.

Existing Reports and Secondary Data: The evaluation team began by conducting a wide-reaching review of existing reports specific to Rhode Island. These resources were reviewed for methodological soundness, data used, and relevance to the CNA requirements, then synthesized. Available national and

state secondary data sources were also reviewed and data from available large datasets were pulled, analyzed, and reviewed for accuracy and limitations. Secondary data from national and local databases, as well as quantitative data gathered via the provider survey, were analyzed using descriptive statistics.

Primary Data: Primary data collection consisted of an online survey of behavioral health, physical health, and social service providers, as well as interviews with individuals currently receiving services from the potential CCBHC and individuals in need of but not currently engaged in such services. The evaluation team distributed a survey to CCBHC staff with direct contact with clients and/or individuals not currently engaged in services, as well as to a wide range of behavioral health, physical health, and social service providers spanning the categories specified in the 2023 CCBHC criteria. Ethnographic interviews were conducted with individuals with lived and/or living experience, including both current clients and individuals not currently engaged in services. Additionally, the evaluation team conducted validation processes with aspiring CCBHCs, interview participants, and survey respondents, in which the team shared findings and solicited reactions and feedback.

Limitations: While secondary data analyses utilized credible and established sources, these sources also had some limitations. These included issues specific to individual datasets; in cases where these issues were sufficient to raise concerns about validity, the datasets were not used or were used in a limited capacity. For most data sources, estimates become less reliable when looking at relatively small populations. In addition, many of the secondary data sources and existing reports incorporated in this CNA underrepresent the challenges facing marginalized individuals; this limitation is discussed in more detail in the main body of this report.

Contextual Factors

Any CCBHC is affected by the circumstances and environments in which it operates, including unique environmental barriers and facilitators that its target populations may experience. This means that the societal context of the model must be examined: without investigating the social and economic factors that give rise to the barriers CCBHC populations face in accessing and engaging with needed services, it is impossible to effectively address those barriers.

Overarching Social and Economic Context: Formidable contextual barriers obscure the needs of individuals within the five CCBHC target populations. It is well established that many of those who need care and support do not receive it. Additionally, many individuals in the CCBHC populations face formidable structural barriers that lead to negative social and economic determinants of health and wellbeing, including but not limited to higher rates of homelessness and incarceration. These relationships between behavioral health and social and economic disadvantage are multifaceted. SMIs and SUDs bring challenges that can make outcomes such as poverty or unemployment more likely, but social and economic difficulties themselves (as well as the structural barriers that contribute to them) can also make individuals more likely to develop SMI or SUD, more likely to have more severe forms of those conditions, and less able to access treatment and recovery. Additionally, the health system often acts as a social determinant of health in its own right, helping to shape the consequences of illness in ways that can make underlying disparities worse. The CCBHC model is an effort to reduce some of these barriers, and the CNA provides key information to guide that effort.

Rhode Island Population, Economics, and Structural Barriers: The secondary data reveal that social and economic characteristics vary substantially within Rhode Island, with deprivation rates being particularly

high in the Providence and Pawtucket regions. These areas also have the largest percentages of residents who were born outside of the United States, speak a language other than English, or are experiencing poverty. Providence County has the highest rates of food insecurity and residents who are covered by Medicaid or uninsured. In addition, both youth homelessness and youth legal system involvement are elevated in the four core cities of Central Falls, Pawtucket, Providence, and Woonsocket compared to the state overall. Across Rhode Island, individuals and families in a range of industries face difficulties in making a living wage. Additionally, individuals from historically marginalized groups face disparities in a wide range of measures—issues which can be expected to be particularly pronounced in Providence and Pawtucket due to their larger proportions of Hispanic or Latino, Black, and (in the case of Providence) Asian residents. Taken together, these structural barriers function as root causes of inequity.

Health System

Secondary data show that substantial behavioral health needs exist across Rhode Island, with Providence County facing particularly high challenges in terms of fatal overdose rates and the Washington and Newport regions facing higher suicide rates. Disparities were also visible across a range of groups, with those who had lower incomes, had a disability, or were LGBTQ often having worse behavioral health outcomes. Disparities by race and ethnicity were also notable; while non-Hispanic White individuals died by suicide more often than other groups, many other measures showed worse outcomes for other racial and ethnic groups. This was particularly marked when looking at overdose fatality rates, but was also visible in areas such as self-reported mental health and suicidal ideation. There is also evidence that individuals from historically marginalized racial and ethnic groups may have higher unmet treatment needs; for example, Hispanic or Latino and Black individuals received methadone treatment at lower rates than non-Hispanic White individuals, and were more likely than non-Hispanic Whites to report poor mental health but less likely to have received a depression diagnosis. These factors represent both intermediate determinants of health and health and wellbeing outcomes.

Synthesis of Findings

Primary data collection was specific to the five priority CCBHC populations and provided insight into individuals particularly needing support and services in Rhode Island, as well as current perceptions of the ease of accessing support and services, barriers to access, and current levels of satisfaction with the range of services available. This information was synthesized with findings from secondary data. Populations that arose as especially needing support included individuals from historically marginalized racial and ethnic groups (in particular, Black, Hispanic or Latino, Indigenous, and Asian and Pacific Islander individuals); people with low incomes and/or who are un- or underinsured; individuals experiencing homelessness or criminal legal system involvement; and individuals with mental health and/or SUD challenges. Additional groups highlighted included children, transition-age youth, elderly or aging individuals, survivors of domestic violence, individuals with intellectual and/or developmental disabilities, LGBTQ individuals, and veterans. Frequently mentioned barriers to service access often overlapped with experiences faced by these groups, including homelessness, lack of affordable housing, lack of a living wage, language and cultural barriers, and stigma. Lack of sufficient providers and insufficient evening and weekend hours also arose as a barrier.

Regarding current perceptions of service accessibility, participants expressed concerns about a range of areas, including support in getting assistance; a variety of substance use and mental health services, including psychiatric rehabilitation; and crisis 24-hour mobile stabilization. Additionally, many participants were unsatisfied with the services currently available for individuals with SMI, SED, SUD, and co-occurring disorders. Quality concerns and negative experiences appeared to contribute both to perceived access challenges and to dissatisfaction with available services. Challenges around uncoordinated transitions between settings and difficulties knowing how to access services also appeared to contribute to low satisfaction.

Considerations

This CNA's data collection, analysis, and validation process revealed many gaps and fault lines, with inequities ingrained throughout. Gaps represent key areas that are missing and that increase access and/or quality concerns. Fault lines are viewed as "breaks" in the functional safety net entrusted with providing vital support and services for the state's most vulnerable and marginalized individuals. Inequity, a formidable factor impeding any transformation effort, is defined as deep-rooted interpersonal and structural barriers that result from pervasive racism, discrimination, and injustice.

Data revealed substantial differences between CCBHC regions, with areas of high-density deprivation that will require different CCBHC models than other parts of the state. Statewide, key fault lines included workforce vacancies, turnover, and burnout, as well as challenges engaging key groups such as unhoused individuals; individuals experiencing stigma, language, and/or cultural barriers; children and transitional-age youth; and individuals involved with the criminal legal system. Gaps included challenges around transitions of care, service awareness, and quality of support and services. The State and other organizations have taken many steps to begin addressing these fault lines, gaps, and inequities, and implementation of the CCBHC model will help to further these efforts.

1. Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) requires that organizations seeking to become Certified Community Behavioral Health Clinics (CCBHCs) conduct a community needs assessment (CNA) for their region. This assessment helps identify individuals who are not engaged in support and services and shapes a wide range of CCBHC elements, including staffing, training, hours, locations, range of services, and community partnerships. To do so, it must address both behavioral health needs and broader social and economic factors present in the community, including incorporating input from community members with lived experience of behavioral health conditions and a wide range of community organizations.[1]

This CNA focuses on Rhode Island as a whole and was completed through a partnership between the state's aspiring CCBHCs (Section 1.2), potential Designated Collaborating Organizations (DCOs), and an outside organization that assisted with data collection and analysis.

1.1. CCBHC Model Background

The CCBHC model represents a new approach to delivering community behavioral health services. Established in 2014 by the Protecting Access to Medicare Act (PAMA),[2] the model requires that CCBHCs provide comprehensive and timely behavioral health services that are person- and family-centered, trauma-informed, and integrate mental health, substance use, and physical health services.[1] While CCBHCs must serve anyone seeking care,[1] the model's creators expected it to particularly provide access, high-quality integrated care, coordination, and improved outcomes for high-acuity individuals.[3] The 2023 SAMHSA requirements define five populations of particular focus within the model:

1. **Individuals with serious mental illness (SMI),**
2. **Individuals with substance use disorders (SUDs),**
3. **Children and adolescents with serious emotional disturbance (SED),**
4. **Individuals with co-occurring mental health and substance use disorders, and**
5. **Individuals "experiencing a mental health or substance use-related crisis."[1]**

These populations represent a significant expansion of outreach, engagement, support, and services and are beyond the scope of a typical community mental health center (CMHC). In addition to changing service delivery, the CCBHC model explores new payment approaches designed to meet the true cost of accessible, integrated care. It does so using a Medicaid matching payment model that increases funding for a full continuum of behavioral health providers, beyond what can typically be reimbursed through traditional Medicaid billing.[2]

1.1.1. Hub-and-Spoke Model

CCBHCs must ensure that their clients have access to nine core services (Figure 1), outlined in detail by the 2023 SAMHSA requirements.[1] To provide this access, CCBHCs may develop contracts with DCOs to provide any of the nine core services, as long as the CCBHC provides at least 51% of total encounters.[1] This flexibility represents a change from previous CCBHC requirements[3] and recognizes that CCBHCs may lack the capacity and/or expertise to provide accessible, high-quality services for the full population targeted by the CCBHC model. Instead, utilizing DCOs allows CCBHCs to partner with other organizations that already provide high-quality services.

Under a Prospective Payment System (PPS) model, DCOs are paid by the CCBHC for the core services they provide. The CCBHC also remains responsible for ensuring that all CCBHC clients have access to the nine core services, even those provided by DCOs. This requirement evokes reservations for some CCBHCs and potential DCOs, as it necessitates a level of cooperation and collaboration that may be new for many. A formal business agreement, such as the written agreement that is required for DCOs providing core CCBHC services,[1] can help to address some of the areas that evoke hesitation. It is also important to note that, while CCBHCs and DCOs must collaborate closely and may choose to co-locate services, this is not required and may not always be in clients' best interest.

In addition to partnering with DCOs, CCBHCs must work with a range of organizations via care coordination agreements (CCAs). Ultimately, these DCO and CCA relationships allow the CCBHC to become the heart of a complex hub-and-spoke model for substance use and mental health services. While there can be a misconception that CCBHCs should provide all required services directly, the reality is that partnering with outside organizations with expertise in specific areas is often a key strategy for CCBHC success.[4] Many CCBHCs that provide most required services directly do so because their region has few quality providers.

Figure 1. Hub and Spoke Model: Ensuring Coordination, Access, and the Provision of Evidence- Based Pathways for Marginalized and Vulnerable Individuals

1.1.2. Community Needs Assessment

One of the key roles of the CNA is to support CCBHCs in developing their hub-and-spoke model in a way that takes advantage of local partnership opportunities and addresses regional needs. The CNA helps enable the CCBHC to work with partners to reach key populations and provide needed services. The CNA is defined in SAMHSA's 2023 CCBHC requirements (see Appendix A) and is completed by the CCBHC or the organization working to become a CCBHC (e.g., through CCBHC attestation or state certification). This organization can work with a partner to assist with data collection and analysis; however, they must use the CNA to develop their staffing and training plans and to develop or modify their engagement and service initiation approaches.

> Community Needs Assessment is a systematic approach to identifying community needs and determining program capacity to address the needs of the population being served. CCBHCs will conduct or collaborate with other community stakeholders to conduct a community needs assessment. The assessment should identify current conditions and desired services or outcomes in the community, based on data and input from key community stakeholders. Specific CCBHC criteria are tied to the community needs assessment including staffing, language and culture, services, locations, service hours, and evidence- based practices. Therefore, the community needs assessment must be thorough and reflect the treatment and recovery needs of those who reside in the service area across the lifespan including children, youth, and families.
>
> *– Source: SAMHSA's 2023 CCBHC Requirements*[1]

The focus of the CCBHC CNA is on assessing the needs of the five CCBHC target populations (listed in Section 1.1) in the organization's community. In this way, it provides data to assist the CCBHC in developing strategies to reach, engage, and ensure continued engagement of each of the CCBHC priority populations, with a deliberate focus on individuals who are not currently engaged in care or services. The CNA must therefore consider continuum and system gaps for all groups making up the five key populations, including children and families, people experiencing homelessness or legal system involvement, and individuals facing structural barriers such as racism and discrimination. It must also incorporate input from stakeholders, especially those with lived and living experiences of behavioral health challenges. Ultimately, the CNA defines the full range of behavioral health needs in the CCBHC's community and drives the work of the CCBHC.

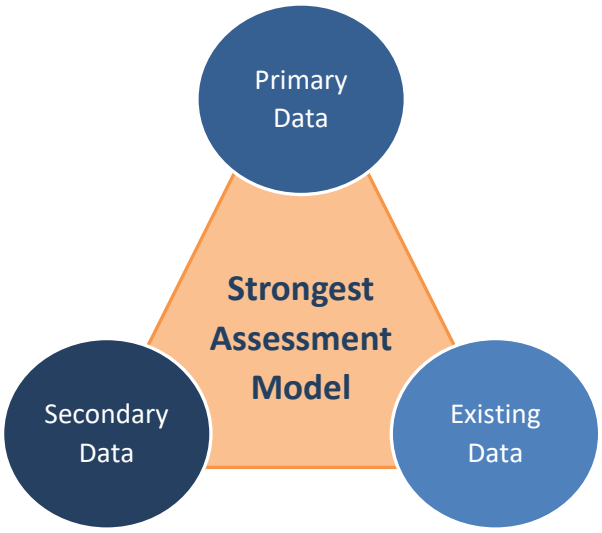
1.2. Rhode Island CCBHC Regions

The State of Rhode Island has selected eight regions for CCBHC development, corresponding with Rhode Island's existing CMHC regions. A map of the eight regions is provided in Figure 3. The regions vary substantially in terms of their populations, social and economic characteristics, and behavioral health landscapes, giving rise to a diversity of needs across the state. These characteristics, variations, and needs are discussed in detail in Section 3, Section 4, and Section 5 of this report.

2. Methodology

This needs assessment uses a mixed-methods (quantitative and qualitative) triangulation methodology, consisting of three main sources of data that together create the strongest assessment and evaluation approach. Specifically, the CNA draws on:

- Existing reports and white papers,
- Secondary data, and
- Primary data.



Each of these data sources is discussed in detail in the sections below, as is the overall data validation and analysis process. The evaluation team worked with each CCBHC and DCO to complete CNA activities in each region. This included partnering with these organizations on primary data collection, as well as utilizing regional assessments that were already completed, underway, or planned. (The evaluation team was also available to provide technical assistance as needed for these regional CNAs, some of which required additional considerations to meet the 2023 CCBHC requirements.)

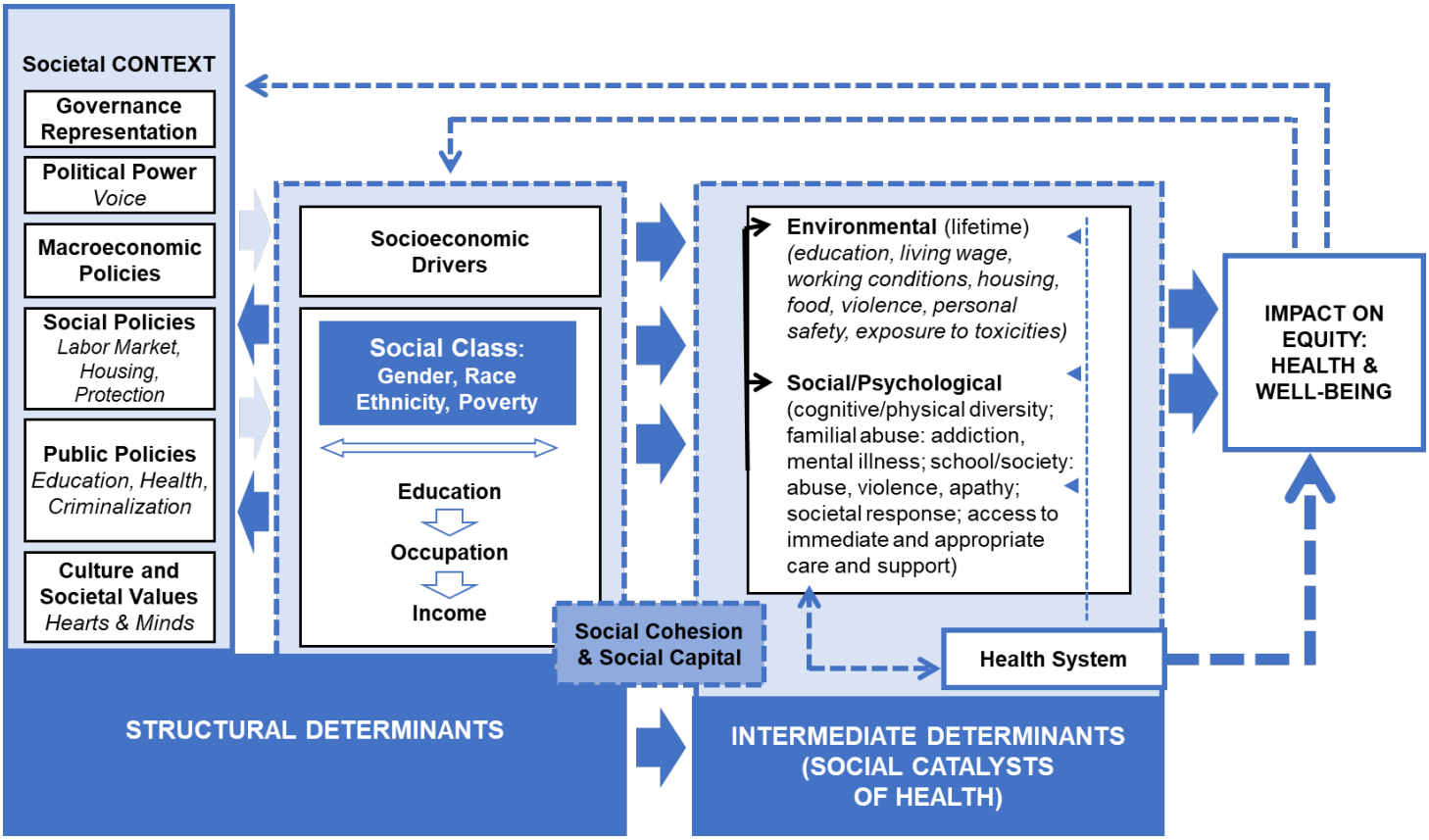
In addition, because inequity and bias are so deeply rooted in society, it can be difficult to see and assess them clearly and objectively. To address this challenge, this CNA uses a conceptual framework. Using a conceptual lens diminishes inherent bias and allows evaluators and readers to view assessments through a wider perspective than their personal experience. The conceptual model for this assessment is based on Benfer's Health Justice framework[5] and the World Health Organization (WHO)'s Conceptual Framework for Action on the Social Determinants of Health,[6] both of which highlight the deep interconnectedness between multiple domains of inequity. These interlinked inequities both increase the prevalence and mask the occurrence of behavioral health conditions among the five CCBHC priority populations.

Each element of the integrated model (Figure 2) is a proven root cause of social and economic determinants of health and wellbeing. WHO's model focuses on addressing the root causes of social and economic determinants of health by identifying the interpersonal and structural barriers that create and cement inequity. Benfer's model aligns with WHO's and adds depth in certain key areas. In the integrated conceptional lens, societal context creates and maintains the foundation for structural barriers to equity. These social and economic drivers act as core catalysts for environmental, social, and psychological forces that perpetuate inequity. Within both the WHO and Benfer models, each domain in the model is linked; therefore, inequity can be addressed at multiple levels.

This CNA began with the key elements of societal context, examining foundational social, political, and economic barriers. This was followed by a deep dive into socioeconomic drivers such as gender, race, ethnicity, and poverty, as well as their role in education, occupation, and income. The analytical lens illustrates how these factors in turn fuel intermediate determinants—the social catalysts of health—that shape the environmental, social, and psychological barriers that people face throughout their lives. This

includes the health system itself, which acts as a structural barrier that functions as another enforcer of inequity.

Figure 2. Equity Conceptual Model



Source: Adapted from Benfer (2015)[5] and Solar & Irwin (2010).[6]

2.1. Existing Reports

The evaluation team began by conducting a wide-reaching review of existing reports specific to Rhode Island. These resources were reviewed by the evaluation team for methodological soundness, data used, and relevance to the CNA requirements, then synthesized. These sources were used to provide information on regional care continuums and community contextual factors, with an emphasis on understanding gaps and fault lines, interventions that have been tried, and intended or unintended outcomes. When possible, the evaluation team pulled data points from reports to include in secondary data analysis (described below). A list of many of the reports reviewed is included in Appendix B.

2.2. Secondary Data

Available national and state secondary data sources were also reviewed (see Appendix B) and data from available large datasets were pulled, analyzed, and reviewed for accuracy and limitations. The evaluation team prioritized data available from 2020 or later, to minimize disruption in comparability and consistency of data quality and collection methods as a result of the COVID-19 pandemic.[7,8] In addition, the team worked to obtain data at the regional level where possible, with city-level data used for some specific analyses or when further aggregation was not feasible. County-level data was also

utilized when further geographic detail was not available, and state-level data was used when discussing Rhode Island as a whole.

Secondary data from national and local databases, as well as quantitative data gathered via the provider survey, were analyzed using descriptive statistics. Where possible, secondary data for specific subgroups are expressed as population rates (e.g., 20 instances per 1,000 people) to allow for comparison of burden across groups of different sizes. These rates were calculated using population data from the American Community Survey (ACS), with 1-year ACS data from the corresponding year used wherever possible. In instances where ACS denominator data were not available, numbers are presented in the format reported by the secondary data source (e.g., 10% of survey respondents).

2.3. Primary Data

The 2023 CCBHC requirements outline the groups that must be involved in the CNA, including advocacy groups, criminal justice agencies, community organizations, individuals with lived and living experience, the full range of providers, and others. Primary data collection consisted of an online survey of behavioral health, physical health, and social service providers, as well as interviews with individuals currently receiving services from a potential CCBHC and individuals in need of but not currently engaged in such services. Important focuses included understanding the factors impeding engagement in services, considering strategies to reach unengaged individuals, and devising interventions to address gaps, fault lines, and inequity (including interpersonal and systemic racism).

2.3.1. Provider Survey

The evaluation team developed a provider survey (Appendix C) based on one utilized by CCBHCs in other states. To customize it for the Rhode Island environment, the team made modifications, solicited input from a potential CCBHC and staff members of other community organizations, and updated the survey based on feedback received. The survey was hosted in Qualtrics and, as noted above, focused on barriers to accessing needed, high-quality services.

Survey distribution particularly targeted CCBHC staff with direct contact with clients and/or individuals not currently engaged in services. In addition, the survey was distributed to a wide range of behavioral health, physical health, and social service providers, spanning the range of categories specified in the 2023 CCBHC criteria. To facilitate this, aspiring CCBHCs were asked to complete a spreadsheet listing community partners and contacts in a range of categories, developed based on CNA requirements. The evaluation team then investigated areas with missing information and identified additional contacts. Categories included:

- Health centers (including Federally Qualified Health Centers [FQHCs]);
- Local health departments;
- Inpatient psychiatric facilities, inpatient acute care hospitals, and hospital outpatient clinics;
- Veterans Affairs (VA) facilities;
- Local school systems;
- Crisis response partners such as hospital emergency departments (EDs), emergency responders, crisis stabilization settings, crisis call centers, and warmlines;
- Organizations operated by people with lived experience of mental health and SUDs;
- Other mental health and SUD treatment providers;
- Residential programs;

- Juvenile justice agencies and facilities;
- Criminal justice agencies and facilities;
- Indian Health Service or other tribal programs;
- Child welfare agencies and state-licensed and nationally accredited child placing agencies for therapeutic foster care service;
- Specialty providers of medications for treatment of opioid use disorder (OUD) and alcohol use disorder (AUD);
- Homeless shelters and housing agencies;
- Employment services systems;
- Services for older adults, such as Area Agencies on Aging;
- Aging and Disability Resource Centers; and
- Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs).

To ensure responses from across the required categories, the evaluation team utilized the following survey distribution and follow-up process:

- Aspiring CCBHCs shared lists of organizations they work with in each of the required inclusion categories, along with contact information. The evaluation team then investigated any missing areas, including via online research, speaking with potential DCOs, and referencing other local resources or reports.
- The evaluation team reached out to identified contacts and requested that they forward the survey information to staff members working directly with clients within each of the organization's service areas.
- As needed, the evaluation team followed up with individuals who did not respond.

2.3.2. Individual Interviews

Ethnographic interviews focused on individuals with lived and/or living experience, including both current clients and individuals not currently engaged in services. Interview content was aimed at better understanding individuals' experiences and the barriers they were facing or had already navigated in attempting to access services. The evaluation team met with individuals until thematic saturation was achieved.[9-11]

Sample Interview Topics

1. Past/present wellbeing
2. Experience with initiating and engaging in services
3. Barriers faced
4. Enablers of engagement
5. Experience with community services
6. Regarding access and treatment:
    a. What needs improvement
    b. What is working well

Interviews started with simple warm-up questions to open the conversation,[9,12,13] after which the interviewer shared the purpose of the CNA and the importance of the participant's input.[10] If the participant agreed to share their experience after hearing this information, the interview then proceeded with general open-ended questions on key topics (see box at left).[9,11,13] A translation service was used to conduct interviews with individuals more comfortable in a language other than English. After the first few interviews, the interview questions and process were adjusted as needed to ensure they addressed the intended content.[11]

Aspiring CCBHCs and DCOs played a central role in participant recruitment. Specific recruitment processes were customized to each organization via consultation between organization staff and the evaluation team; however, overall approaches were similar and prioritized the comfort and convenience of both organization staff and potential participants. Staff members of aspiring CCBHCs and DCOs informed clients about the CNA during the normal course of their interactions and asked if they were willing to be contacted by an evaluation team member to learn more. If the person agreed, organization staff provided that person's phone number (but no other identifying information) to the evaluation team. An interviewer then called the person to explain the CNA and, if the person agreed, conduct the interview. For individuals without reliable phone numbers, staff members provided use of one of the organization's telephones.

Individuals had to be at least 18 to participate in interviews. Since this assessment was exempt from Institutional Review Board (IRB) review, written consent for interviews was not required; however, each potential participant was informed about the CNA evaluation, the importance of hearing their perspective, that whatever they shared would be kept confidential, and that they could decide to end the conversation at any time or not answer any questions that they did not wish to answer.[13]

All participants were offered a gift card to a local store (e.g., CVS, Dunkin' Donuts, or grocery stores that did not sell alcohol). This helped acknowledge participants' contribution and time, and also served as an incentive to increase participation. However, participants were not required to accept the gift card.

Individuals who agreed to an interview were asked if they would like to be contacted for a follow-up conversation. This follow-up was completed one to two months after the initial interview, using similar processes. However, the content of the conversation differed from the initial interview: the purpose of the follow-up conversation was to share a summary of the CNA findings and ask for the person's feedback. Participants again had an opportunity to decline participation, and those who completed the second conversation were again offered a gift card.

2.3.3. Primary Data Analysis and Validation

The evaluation team analyzed interview data and free-text survey items using matrix templates to identify common themes (see steps outlined in box at right).[9,11] Matrix templates were developed based on the contextual framework presented in Section 2. In addition, descriptive statistics were used to summarize multiple choice and Likert scale survey items. Individual survey responses were included in multiple regions if the person or organization served multiple areas; as a result, regional totals do not sum to the statewide total. In addition, because survey respondents had the opportunity to skip questions, minor variation in totals exist across survey questions. Analysis of interview and survey data began during data collection, so that the evaluation team could become familiar with the data and had an opportunity to adjust future interviews based on lessons learned and emerging findings.[9,11]

Qualitative Data Analysis Steps:

1. Prepare data (e.g., interview notes, validation meeting notes, free-text survey responses) for analysis
2. Review data, noting themes or overall impressions
3. Select one data source and read again, assigning themes to segments of text based on emerging commonalities and the conceptual frameworks
4. List all themes used, eliminating and combining as necessary
5. Using the resulting list, test other data sources, revising as needed
6. After review and theming is complete, review results to identify common themes
7. Consider potential relationships between identified themes

Sources: Creswell (2014)[9] and Merriam (2009)[11]

Assessment validity was promoted using a range of strategies (Table 1). Because the CNA incorporated multiple data sources, each offering a different perspective on key themes, findings could be triangulated across these various lenses.[9,11] The evaluation team also shared initial findings with CNA participants, performing member checking to ensure that results resonated with their experiences and perspectives.[9,11] This was accomplished via two main approaches:

- To validate and share the major themes expressed by interview and survey participants, meetings were held with participating organizations to present and solicit feedback on the gathered perspectives. This led to a discussion on what meeting participants saw as continuum gaps, barriers to accessing high-quality services, and facilitators of access and change. Providers also shared achievements they had made and initiatives they were working on. Meetings were held virtually and efforts were made to schedule the meetings at convenient times for organization participants.
- As discussed above, the evaluation team conducted follow-up conversations with interview participants who agreed to be contacted again. These follow-up calls were an opportunity to share CNA findings and gather individuals' feedback.

In addition, the evaluation team employed regular internal communication to ensure that emerging findings were consistent with the perceptions of those involved in each component of the assessment (e.g., conducting interviews, analyzing survey data, reviewing secondary data).[9] The team also practiced transparency by reporting detailed methods and including any contradictory evidence in assessment findings.[9]

Table 1. Strategies Used to Increase Validity

Approach	Method
Member Checking	• Incorporating evaluation team review of analysis template and categories • Incorporating CNA participant review of aggregated themes
Data Triangulation	• Incorporating three key types of data (primary, secondary, and existing) • Interviewing and surveying groups with multiple perspectives • Validating perspectives with national/state/regional findings • Validating perspectives with individuals with lived/living experience • Drawing connections to the wider literature and context
Transparency	• Reporting detailed methods, including data collection activities and reason for choosing the utilized approach • Reporting contradictory evidence as part of findings

2.4. Limitations

While secondary data analyses utilized credible and established sources, these sources also had some limitations. These included the fact that ACS data for 2020 is experimental[i] due to the COVID-19 pandemic[14,15] and that Rhode Island Department of Health (RIDOH) data on ED visits could not be used due to including only the primary diagnosis and excluding visits that led to hospitalization. (RIDOH hospitalization data included primary and secondary diagnoses only.) Additionally, while Rhode Island's

[i] As with all research in 2020, there were issues with non-response for the 2020 ACS data, including lower response rates among survey recipients with lower socioeconomic status. To combat this, the Census Bureau used entropy-balance weighting (EBW) for 2020 data and released this single year data as experimental data. The methodology for five-year ACS estimates that include the year 2020 was also modified to incorporate the EBW approach.

Behavioral Health Online Data (BHOLD) system was reviewed, multiple aspiring CCBHCs noted that these data did not match their internal records, and these concerns were echoed in System Review meetings conducted with CMHCs by Rhode Island's Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). Nevertheless, BHOLD provided some context for the portion of the CCBHC populations currently reached by BHDDH-licensed behavioral health providers.

Across all data sources, smaller sample sizes lead to higher margins of error, meaning that estimates for relatively small populations are less reliable than those for larger groups. This constraint, as well as data formatting decisions on the part of report authors, meant that disaggregation also posed a challenge in some instances, limiting available geographic or subpopulation detail. Because of this, analyses were unable to explore the specific experiences of some key groups, such as the Cape Verdean population.

Finally, it is important to note that many of the secondary data sources and existing reports incorporated in this CNA underrepresent the challenges facing marginalized individuals. Many existing reports were completed at the state level; this degree of aggregation masks the inequities faced by marginalized groups and geographic communities, particularly when prevalence rates are calculated relative to the entire state population rather than within specific subpopulations. Additionally, many of the secondary data in this report come from community surveys such as the National Survey on Drug Use and Health (NSDUH), which typically underrepresent and sometimes actively exclude disenfranchised groups such as individuals experiencing homelessness or living in institutional settings such as jails, prisons, and mental health facilities.

3. Contextual Factors

Any CCBHC is affected by the circumstances and environments in which it operates, including unique environmental barriers and facilitators that its target populations may experience (presented in Figure 2, the Equity Conceptual Model). This means that the societal context of the model must be examined: without investigating the social and economic factors that give rise to the barriers CCBHC populations face in accessing and engaging with needed services, it is impossible to effectively address those barriers. The CNA is designed to identify these factors in order to facilitate effective model development and implementation.

This section provides information regarding Rhode Island's populations and economic drivers of inequity, based on analysis of secondary data and existing reports. It also provides a general overview of the relationship between social and economic factors and behavioral health needs based on existing literature. Importantly, statistics for the state overall often mask substantial variation across regions, and as a result do not adequately reflect the diversity that exists within Rhode Island. Because local community characteristics and needs drive the CNA, the below sections discuss geographic variation, and additional breakdowns by CCBHC region and/or county are available in Appendix D.

3.1. Overarching Social and Economic Context

Formidable contextual barriers obscure the needs of individuals within the five CCBHC target populations (listed in Section 1.1). It is well established that many of those who need care and support do not receive it. According to the 2021 NSDUH, one out of three people with SMI in the past year, including those with co-occurring SUD, did not receive mental health and/or SUD treatment services, highlighting a substantial gap in care provision.[16] Data from the 2016 National Survey of Children's Health show that half of children with a treatable mental health disorder did not receive treatment,

further emphasizing the critical need for improved access and utilization of mental health services.[17] Additionally, in the NSDUH survey, only 6.8% of people ages 12 and older in need of substance use treatment in the past year received treatment in a specialty facility. The vast majority (96.8%) of people who did not receive treatment did not feel they needed it, while 2.1% (or 837,000 people) felt they needed treatment but did not seek it out. Another 1.1% (or 447 people) tried to seek treatment but could not access it.[16]

Additionally, individuals in the five CCBHC populations face formidable structural barriers, which in turn lead to negative social and economic determinants of health and wellbeing. Many of those with the most acute conditions are Medicaid beneficiaries; others have no health insurance coverage. Homelessness[18,19] and incarceration[20-23] are disproportionately common among both individuals with SMI and individuals with SUDs. A review of data from multiple high-income countries estimated that over three-quarters of individuals experiencing homelessness had a current mental illness; specifically, over a third had AUDs, over a fifth had drug use disorders, over a tenth had schizophrenia spectrum disorders, and over a tenth had major depression.[18] In the United States (US), on a single night in 2020, an estimated 21% of people experiencing homelessness had SMI and an estimated 17% had SUD.[19] Additionally, SMI is estimated to be three to five times more common[21] among those incarcerated than among the general population, while SUD is estimated to be over six times more common.[22,24] For those on probation, a 2020 analysis suggested that SMI is twice as common[25] and SUD is more than three times as common[26] as among non-institutionalized individuals who are not on probation.

Social and economic disadvantage have a nuanced relationship with behavioral health. On one hand, conditions such as SMIs and SUDs bring challenges that can make outcomes such as poverty or unemployment more likely.[27] On the other hand, social and economic difficulties themselves (as well as the structural barriers that contribute to them) can make individuals more likely to develop SMI or SUD, more likely to have more severe forms of those conditions, and less able to access treatment and recovery.[27-30] OUDs provide one example of these interconnected factors. OUD is more likely, more severe, and more difficult to recover from when someone is experiencing challenging social, economic, cultural, and/or environmental circumstances.[31-35] A partial list of factors known to complicate OUD recovery includes homelessness, involvement with the criminal legal system, and reentry after incarceration (all of which are also associated with high risk of overdose);[34,36-39] financial and insurance-related barriers;[32-34] and logistical challenges such as lack of transportation, identification documents, and working phones.[33,40,41] Because individuals from marginalized racial and ethnic groups disproportionately experience a wide range of negative social and economic circumstances,[42-45] they are affected by these challenges at higher rates. Additionally, all of these challenges are further exacerbated by fragmented treatment systems[34,46] with limited capacity, long waiting lists, and insufficient use of medications for addiction treatment (MAT).[33,34,41,47,48]

Additional factors further complicate these interwoven relationships. For example, adverse childhood experiences—also more common among marginalized groups[49]—are associated with greater rates of SUD and mental illness.[50,51] Stigma also plays an important role, with negative attitudes toward individuals with SUDs persisting both in society at large[52-54] and within the medical system itself.[33,52,53,55-57] Such stigma is often internalized by patients[32,33,53,58] and is a formidable barrier to developing an evidence-based continuum of services for individuals trying to survive addictions.[59]

These daunting barriers create a challenging landscape for those living with behavioral health conditions. The CCBHC model seeks to reduce these challenges by integrating the physical, mental health, and SUD continuums and creating partnerships to provide key services such as outreach, harm reduction, recovery and treatment pathways, care coordination, gap mitigation, and follow-up care. In this way, CCBHCs aim to create a strong continuum of outreach and services that can address both complex clinical needs and structural barriers to health and wellbeing. However, it is important to note that weak or missing elements on any of these continuums can hamper the effectiveness of the entire system in improving the health and wellbeing of individuals most in need. Indeed, the health system often acts as a social determinant of health in its own right, helping to shape the consequences of illness in ways that can either mitigate or exacerbate the inequities produced elsewhere in society.[6] In environments where the most vulnerable individuals are also often the least able to access quality care when they need it, the health system makes underlying disparities worse. The CCBHC model is an effort to reduce some of these barriers, and the CNA provides key information to guide that effort.

3.2. Rhode Island Population: Race, Ethnicity, Language, and Place of Birth

Table 2 provides an overview of residents' race, ethnicity, language, and place of birth in Rhode Island and the US. (A breakdown by CCBHC region, as well as information on additional demographic measures, is available in Table D1 in Appendix D.) While non-Hispanic White individuals make up about 71% of all Rhode Islanders, this varies substantially by CCBHC region. In both the Providence and Pawtucket regions, non-Hispanic White individuals are in the minority (34% and 41%); in contrast, they account for 90% of residents in the Washington region, 87% in Kent, and 85% in both Bristol/East Bay and Newport. Following the opposite pattern, Hispanic or Latino populations are largest in the Providence (43%) and Pawtucket (36%) regions and smallest in the Washington (4%), Bristol/East Bay (5%), and Kent and Newport (6%) regions. A similar distribution holds for non-Hispanic Black individuals, who make up 13% of the population in both the Providence and Pawtucket regions but only 1% of the population in Washington. Providence also has the highest percentage of non-Hispanic Asian individuals (6%), followed by the Northern RI and Johnston/West regions (4%).

While 14% of Rhode Islanders were born outside the US, this figure is as high as 31% in Providence and 28% in the Pawtucket region. It is lowest in Washington, where only 5% of residents are foreign-born. Similarly, the proportion of residents who speak a language other than English at home (22% statewide) is highest in Providence (49%) and the Pawtucket region (46%) and lowest in the Washington (6%), Newport (9%), and Kent (9%) regions. Among individuals speaking a language other than English, Providence and Pawtucket have the largest percentages of Spanish-speakers, Bristol/East Bay and Newport have the largest percentages of speakers of other Indo-European languages, and Washington and Kent have the largest percentages of speakers of Asian and Pacific Island languages.

Table 2. Race, Ethnicity, and Language in Rhode Island and the United States

	Rhode Island # (%)	United States # (%)
Total Population	1,091,949	329,725,481
Race and Ethnicity		
White, non-Hispanic	770,700 (70.6)	196,010,370 (59.4)
Hispanic or Latino	178,673 (16.4)	60,806,969 (18.4)
Mexican	11,621 (6.5)	36,983,682 (60.8)
Puerto Rican	47,087 (26.4)	5,857,466 (9.6)

	Rhode Island # (%)	United States # (%)
Cuban	2,020 (1.1)	2,369,179 (3.9)
Dominican	55,551 (31.1)	2,203,172 (3.6)
Central American	35,613 (19.9)	5,791,215 (9.5)
South American	17,974 (10.1)	4,068,949 (6.7)
Other Hispanic or Latino	8,807 (4.9)	3,533,306 (5.8)
Black or African American, non-Hispanic	59,203 (5.4)	40,196,302 (12.2)
Asian, non-Hispanic	37,153 (3.4)	18,554,697 (5.6)
American Indian and Alaska Native, non-Hispanic	2,968 (0.3)	1,936,842 (0.6)
Native Hawaiian and Other Pacific Islander, non-Hispanic	539 (0.05)	555,712 (0.2)
Some other race, non-Hispanic	8,033 (0.7)	1,208,267 (0.4)
Two or more races, non-Hispanic	34,680 (3.2)	10,456,322 (3.2)
Place of birth		
US born	936,369 (85.8)	284,880,673 (86.4)
Foreign born	155,580 (14.2)	44,844,808 (13.6)
Language Spoken at Home*		
Only English	804,411 (77.6)	243,098,950 (78.3)
Other than English	232,168 (22.4)	67,203,410 (21.7)
Spanish	131,450 (56.6)	41,157,140 (61.2)
Speak English less than very well	55,257 (42.0)	16,079,944 (39.1)
Other Indo-European languages	67,937 (29.3)	11,525,491 (17.2)
Speak English less than very well	20,050 (29.5)	3,497,837 (30.3)
Asian and Pacific Island languages	23,302 (10.0)	10,906,763 (16.2)
Speak English less than very well	9,021 (38.7)	4,875,197 (44.7)
Other languages	9,479 (4.1)	3,614,016 (5.4)
Speak English less than very well	2,918 (30.8)	1,082,281 (29.9)

Source: American Community Survey, 2021 5-Year Estimates.[60-63]

** The denominator for this group is the population aged 5+, so percentages are calculated using this denominator (not shown) and not the total population reflected in the table.*

3.3. Rhode Island Economics and Structural Barriers

Poverty and Food Insecurity: Table 3 provides an overview of residents' poverty status, WIC and SNAP[ii] participation, and educational attainment in Rhode Island and the US. (A breakdown by CCBHC region is available in Table D2 in Appendix D.) Among those for whom poverty status is estimated, 11% in Rhode Island overall are below the federal poverty level; this rate is nearly double in Providence (22%) and is also above the statewide rate in the Pawtucket region (17%), while other regions are near or below the statewide rate. Similarly, 15% of Rhode Island households are receiving food stamps/SNAP, while this rate is 29% in Providence and 24% in the Pawtucket region (with other regions again equal to or below the statewide rate).

[ii] WIC: Special Supplemental Nutrition Program for Women, Infants, and Children; SNAP: Supplemental Nutrition Assistance Program

Table 3. Social and Economic Comparison of Rhode Island and the United States

	Rhode Island # (%)	United States # (%)
Total Population	1,091,949	329,725,481
Poverty Status in Past 12 Months		
Population where poverty status is estimated	1,050,314 (96.2)	321,897,703 (97.6)
Below federal poverty level	118,257 (11.3)	40,661,636 (12.6)
Above federal poverty level	932,057 (88.7)	281,236,067 (87.4)
Food Stamps/SNAP		
Total households	426,769	124,010,992
Receiving SNAP	62,811 (14.7)	14,105,231 (11.4)
With children under 18	24,531 (39.1)	6,860,455 (48.6)
No children under 18	38,280 (60.9)	7,244,776 (51.4)
Not receiving SNAP	363,958 (85.3)	109,905,761 (88.6)
Women & Children Participating in WIC*		
Estimated eligible	39,843	—
Estimated enrolled	16,022 (40.2)	—
Education**		
Less than high school degree	92,651 (10.5)	28,687,047 (11.2)
High school degree	433,560 (49.3)	126,014,864 (49.3)
College degree or higher	353,075 (40.2)	100,789,495 (39.4)

Source: American Community Survey, 2021 5-Year Estimates,[60,64-66] except where otherwise noted.

** Data as of June 2022. Source: 2023 Rhode Island KIDS COUNT Factbook.[67]*

*** The denominator for this group is the population aged 18+, so percentages are calculated using this denominator (now shown) and not the total population reflected in the table.*

Additionally, 9% of Rhode Islanders experience food insecurity,[68] with the rate for Providence County being very similar to the statewide rate and the rates for all other counties being lower (see Table D3 in Appendix D). In Providence County, 65% of people experiencing food insecurity earn less than the SNAP eligibility threshold, while the same is true of 48% of all Rhode Islanders experiencing food insecurity. Statewide, there are disparities in food insecurity by race and ethnicity, with about 7% of non-Hispanic White Rhode Islanders being food insecure, compared to 15% of Hispanic or Latino Rhode Islanders and 18% of non-Hispanic Black Rhode Islanders.

Homelessness: Substantial disparities exist in homelessness. On a single night in 2021, 10 out of 10,000 White individuals (of any ethnicity) were experiencing homelessness, compared to 80 out of 10,000 Black individuals, 60 Native Hawaiian or Other Pacific Islander individuals, and 55 American Indian or Alaska Native individuals. Similarly, 11 out of 10,000 non-Hispanic/Latino individuals were experiencing homelessness on the night of the count, compared to 16 out of 10,000 Hispanic or Latino individuals.[69] In addition, 1,461 of the state's 138,566 enrolled students (10.5 per 1,000) were identified as homeless by school personnel during the 2021-2022 school year, with this rate being higher in the four core cities of Central Falls, Pawtucket, Providence, and Woonsocket (16.8 per 1,000).[67]

Legal system involvement: Statewide incarceration rates demonstrate troubling inequity. Black individuals made up 24% of commitments, 28% of those awaiting trial, and 40% of those sentenced, despite being less than 10% of the state's population. Similarly, Hispanic individuals make up 16% of Rhode Island's population, but 21% of commitments, 27% of those awaiting trial, and 26% of those

sentenced. White individuals, in contrast, accounted for just 50% of commitments, 40% of those awaiting trial, and 40% of those sentenced, despite making up a large majority of the state's population.[70] Approximately 28% of people being released from incarceration are released to Providence, higher than the proportion released to any other city or town in the state; the smallest proportions are released to the Newport (4.8%), Bristol/East Bay (5.0%), and Washington (6.3%) regions.[71] Regarding youth legal system involvement, in 2022, Rhode Island had 357 youth on probation (4.2 per 1,000) and 164 youth at the Rhode Island Training School (RITS; 1.9 per 1,000). Both rates were higher in Rhode Island's four core cities (7.9 and 4.2 per 1,000) than for the state overall.[67,iii]

Insurance coverage: Overall, 3% of Rhode Islanders are uninsured and 27% are covered by Medicaid (see Table D4 in Appendix D); in both cases, rates are highest in Providence County (4% and 33%) and second-highest in Newport County (3% and 22%). Newport County also has a particularly high percentage of individuals covered by military insurance (13% compared to 4% in the state overall). On both the state and county levels, insurance coverage shows disparities across race and ethnicity (Table 4; also see Table D5 in Appendix D). About 18% of non-Hispanic White individuals in the state are covered by Medicaid and 1.6% are uninsured, while these figures are 58% and 8% for Hispanic or Latino residents and 41% and 5% for non-Hispanic Black residents. Insurance disparities are also clear by place of birth, with 42% of Rhode Islanders born outside the US being covered by Medicaid and 7% being uninsured, compared to 24% and 2% of those born in the US.

Table 4. Insurance Status of Rhode Islanders by Selected Demographic Categories, 2022

	White, non-Hispanic # (%)	Hispanic or Latino # (%)	Black, non-Hispanic # (%)	Asian, non-Hispanic # (%)	Born in US # (%)	Born outside US # (%)
Total Population	736,895	170,739	53,364	36,403	905,217	142,353
Private Insurance	409,697 (55.6)	37,942 (22.2)	21,805 (40.9)	26,977 (74.1)	462,918 (51.1)	47,851 (33.6)
Medicaid	133,171 (18.1)	99,560 (58.3)	21,642 (40.6)	5,032 (13.8)	217,696 (24.0)	59,917 (42.1)
Medicare	152,187 (20.7)	17,638 (10.3)	6,313 (11.8)	2,173 (6.0)	167,915 (18.5)	23,095 (16.2)
Military Insurance	30,394 (4.1)	1,852 (1.1)	— (1.3)	— (1.8)	36,385 (4.0)	— (1.1)
Uninsured	11,445 (1.6)	13,748 (8.1)	2,917 (5.5)	— (4.3)	20,303 (2.2)	9,979 (7.0)

Source: 2022 Health Insurance Survey.[72]

Living wage: The living wage is the estimated annual budget required to support a family of a given size in a given geographic area, and can provide insight into people's economic experiences in a region (see Table 5).[73] For those working in retail trade, the average annual wage[74] is $39,893 in Rhode Island overall; this constitutes a living wage only for a single adult with no children. The average annual wage for those working in health care and social assistance is $58,161, which is a living wage only for those without children. As a final example, the average annual wage for individuals working in accommodation and food services is $27,895, which is less than the living wage for one adult with no children.

[iii] Note: Rates are calculated using 2010 population data provided by Rhode Island KIDS COUNT.

Table 5. Typical Expenses by Family Size and Composition in Rhode Island (USD)

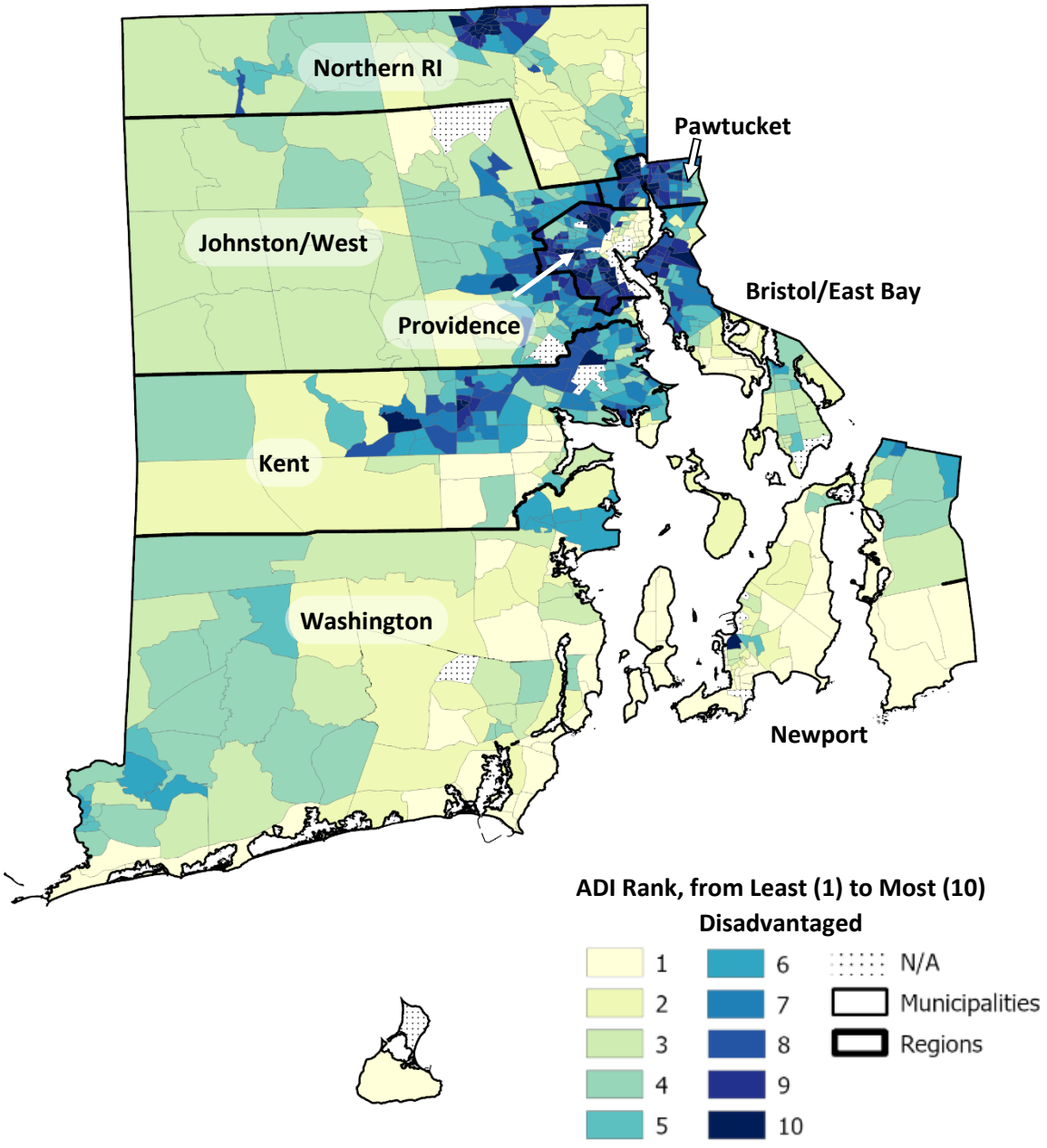
# of Adults	1 Adult				2 adults (1 working)				2 adults (both working)			
# of Children	0	1	2	3	0	1	2	3	0	1	2	3
Food	4,559	6,729	10,111	13,402	8,359	10,413	13,429	16,341	8,359	10,413	13,429	16,341
Childcare	0	10,165	20,330	30,495	0	0	0	0	0	10,165	20,330	30,495
Medical	3,568	9,026	9,036	8,961	7,069	9,036	8,961	9,114	7,069	9,036	8,961	9,114
Housing	11,421	15,441	15,441	19,284	12,792	15,441	15,441	19,284	12,792	15,441	15,441	19,284
Transportation	4,470	8,040	9,831	11,821	8,040	9,831	11,821	12,675	8,040	9,831	11,821	12,675
Civic	2,882	5,725	6,394	8,719	5,725	6,394	8,719	6,933	5,725	6,394	8,719	6,933
Other	4,339	7,570	8,932	9,804	7,570	8,932	9,804	10,966	7,570	8,932	9,804	10,966
Required annual income after taxes	31,371	62,828	80,207	102,618	49,686	60,179	68,306	75,444	49,686	70,344	88,637	105,940
Annual taxes	5,072	11,238	15,636	22,996	7,089	9,385	11,127	12,638	7,089	11,763	15,885	19,774
Required Annual income before taxes	36,443	74,066	95,844	125,614	56,775	69,564	79,434	88,083	56,775	82,108	104,521	125,714

Source: Living Wage Calculator.[73]

3.4. Validation of Contextual Findings

The Area Deprivation Index (ADI; Figure 3) is a measure of socioeconomic disadvantage that combines 17 Census measures on poverty, education, housing, and employment in order to rank the relative advantage or disadvantage of a neighborhood.[75-77] These measures reflect key elements of the Equity Conceptual Model (Figure 2) necessary to identify populations that face structural barriers. The below map shows the ADI for Rhode Island, with the darkest colors representing the block groups (neighborhoods) that are most disadvantaged relative to the rest of the state. Table 6 presents the number of neighborhoods ranking a 10 on the ADI (indicating the highest levels of disadvantage compared to other areas within the state) in each of the Rhode Island CCBHC regions.

Figure 3. Area Deprivation Index (comparison within Rhode Island)



The ADI shows clear variation between Rhode Island CCBHC regions, underscoring the importance of taking a regional rather than a statewide view. The Providence region has the highest number of neighborhoods ranking a 10, with 29 neighborhoods falling into that category. These neighborhoods are home to a total population of 31,756 people. Providence is followed by the Pawtucket region, which has 21 neighborhoods ranking a 10, with a cumulative population of 30,560. In descending order, the other CCBHC regions are:

- Northern RI, with 14 neighborhoods ranking 10 and a cumulative population of 15,972 in those neighborhoods;

- Kent, with 5 neighborhoods ranking 10 and a cumulative population of 5,272;
- Johnston/West, with 3 neighborhoods ranking 10 and a cumulative population 4,376;
- Bristol/East Bay, with 3 neighborhoods ranking 10 and a cumulative population of 2,382;
- Newport, with 1 neighborhood ranking 10 and a population of 2,403; and
- Washington County, with no neighborhoods ranking 10.

Table 6. Area Deprivation Index: Number of Neighborhoods Ranking 10, by Region

CCBHC Region	Number of Neighborhoods Ranking 10	Number of Cities with Neighborhoods Ranking 10	CMHC	Population in Neighborhoods Ranking 10
Providence	29	1 (Providence)	The Providence Center	31,756
Pawtucket	21	2 (Pawtucket, Central Falls)	Gateway Healthcare (Pawtucket)	30,560
Northern RI	14	2 (Woonsocket, North Smithfield)	Community Care Alliance	15,972
Kent	5	3 (West Warwick, Warwick, Coventry)	Thrive Behavioral Health	5,272
Johnston/West	3	1 (Cranston)	Gateway Healthcare (Johnston)	4,376
Bristol/East Bay	3	1 (East Providence)	East Bay Mental Health	2,382
Newport	1	1 (Newport)	Newport Mental Health	2,403
Washington County	0	0	Gateway (Charlestown)	0

Note: Ranks are as compared to the rest of Rhode Island. For a map of nationwide ADI percentile rankings, see Figure D1 in Appendix D.

3.5. Summary of Contextual Findings

The secondary data reviewed above reveal that social and economic characteristics vary substantially within Rhode Island, with deprivation rates being particularly high in the Providence and Pawtucket regions. These areas also have the largest percentages of residents who were born outside of the US, speak a language other than English, or are experiencing poverty. Providence County has the highest rates of food insecurity and residents who are covered by Medicaid or uninsured. In addition, both youth homelessness and youth legal system involvement are elevated in the four core cities of Central Falls, Pawtucket, Providence, and Woonsocket compared to the state overall. Across Rhode Island, individuals and families in a range of industries face difficulties in making a living wage. Additionally, individuals from historically marginalized groups face disparities in a wide range of measures—issues which can be expected to be particularly pronounced in Providence and Pawtucket due to their larger proportions of Hispanic or Latino, Black, and (in the case of Providence) Asian residents. Taken together, these structural barriers function as root causes of inequity (see Figure 2, the Equity Conceptual Model).

4. Health System

This section focuses on behavioral health within Rhode Island, using secondary data and existing reports. As noted in the Equity Conceptual Model (Figure 2), the health system often acts as a barrier to

health and wellbeing. In doing so, it perpetuates inequity. For example, marginalized groups often face systemic barriers such as stigma, discrimination, and cultural insensitivity in primary care and mental health care settings, which can deter them from seeking treatment.[78,79] Additionally, limited access to affordable and culturally competent mental health services further exacerbates disengagement among these populations.[78,80]

Waiting lists are one outward sign of a lack of sufficient access to care and resources. In January to September 2023, for Rhode Island overall, the monthly average number of people waiting in the ED for an inpatient behavioral health placement varied from 30 to 49, with an average of 38. During that same time, the average monthly wait time for recovery housing varied from 13.0 to 25.6 days, with an average of 20.4 days. While monthly averages are not available for individuals waiting for a group home placement via the Mental Health Psychiatric Rehabilitative Residences (MHPRR) program, data show that on August 23, 2023, there were 19 individuals waiting in community settings for such placements, 15 individuals waiting in a psychiatric unit at a community hospital, 11 individuals waiting in forensic settings, and less than 5 people waiting in both corrections and respite/crisis stabilization unit (CSU) settings.[81]

Evidence of similar challenges emerged during System Review meetings conducted by BHDDH with CMHCs. For example, in the Providence region in 2023, participants in these conversations brought up concerns that EDs were overwhelmed by the number of patients they were receiving, communication was not flowing effectively between different agencies working with the same clients, and insufficient recovery housing resources were available for clients leaving residential SUD treatment. Participants also noted barriers faced by specific populations, such as people with mental health conditions, non-English speakers, and adults with intellectual and/or developmental disabilities. Issues related to coordination across different organizations also arose as a theme across many of the other CCBHC regions; as additional examples, meetings in the Pawtucket region during the same time period discussed efforts to improve communication between the police department and behavioral health providers, while meetings in Northern RI discussed the need for greater coordination with hospitals regarding admission notifications and discharge planning.

4.1. Mental Health

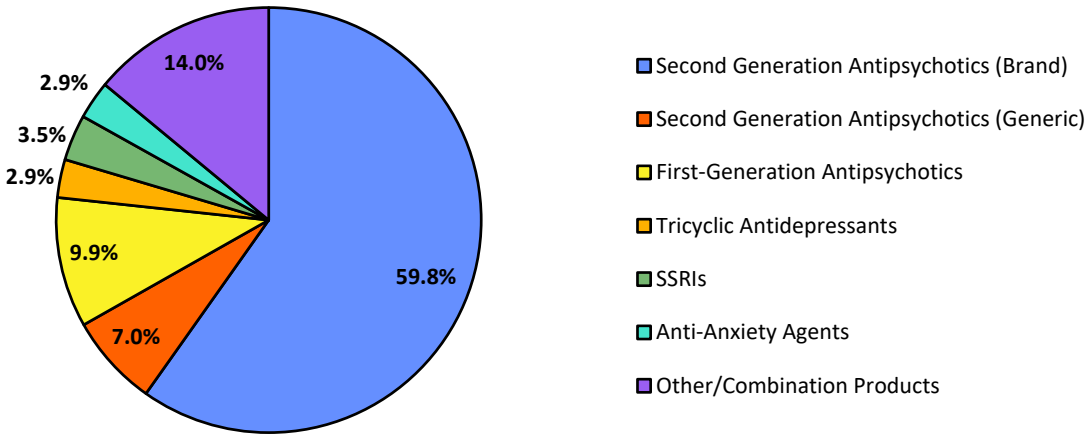
The 2021 NSDUH estimated that, in the past year, 25.9% of Rhode Island adults had any mental illness and 6.0% had an SMI;[82] both of these were slightly higher than the national rates (22.8% and 5.5%).[83] Per the 2023 *Rhode Island KIDS COUNT Factbook*, 26% of children age 18 or younger who were enrolled in Medicaid had a mental health diagnosis.[67] BHOLD data suggest that in 2022, approximately 23 out of every 1,000 Rhode Islanders received mental health services from BHDDH-licensed providers.[81] Additionally, data from the 2022 Health Insurance Survey indicate that 18.1% of Rhode Islanders of all ages had received mental health care in the past year. Approximately 8% of Rhode Islanders reported that they had to delay or forgo needed mental health care in the past year due to no provider being available, an increase from previous survey years in which this rate had hovered around 5%.[72]

Mental health concerns are consistently among the most common diagnoses for hospital discharges in Rhode Island.[84] In 2022, depressive disorders were the third most common diagnoses for hospitalizations, schizophrenia spectrum and other psychotic disorders were fifth, and bipolar and related disorders were tenth. Overall in 2022, Rhode Island as a whole had 11,090 hospital discharges with a “mental diseases and disorders” diagnosis, or 10.1 per 1,000 Rhode Islanders. These data

highlight that mental health is a leading concern and highly prevalent among both adults and children in Rhode Island. Although mental health is still a concern amongst older adults (ages 65+), these diagnoses were not amongst the top 15 most common for this group, with other health issues taking priority. In contrast, trauma- and stressor-related disorders were the most common hospital discharge diagnoses among 5- to 9-year-olds, and the majority of hospitalizations among 10- to 14-year-olds and 15- to 19-year-olds in 2022 were mental health–related. The rate of hospital discharge with a mental health diagnosis for those aged 15-19 (10.4 per 1,000 in 2022) was high compared to other age groups. Additionally, rates of discharge from the hospital with a mental health diagnosis show disparities by race/ethnicity (see Table D6 in Appendix D), with the rate for non-Hispanic Black individuals (22.2 per 1,000) being notably higher than the overall population rate.

Importantly, data from Rhode Island Department of Corrections (RIDOC), reported by the Mental Health Association of Rhode Island and the Brown Initiative for Policy,[85] suggest that through May 2021, a large portion of incarcerated individuals were also experiencing mental health difficulties.[iv] An average of 35.4% of inmates were on psychiatric medications from 2017-2020. The medication expenditures (Figure 4) suggest that many of those incarcerated have mental health concerns related to schizophrenia spectrum or other psychotic symptoms, with nearly 80% of psychiatric medication expenditures being used on antipsychotics from June 2020-May 2021. Some are also experiencing depression or anxiety symptoms, with approximately 10% of expenditures being used for antidepressants and antianxiety medications. Because individuals from marginalized racial and ethnic groups are incarcerated at disproportionate rates (see Section 3.3), it is likely that they are also disproportionately represented among those experiencing these challenges. Additionally, this can be expected to more strongly affect regions, such as Providence, that receive larger numbers of individuals being released from incarceration.

Figure 4. Breakdown of Total RIDOC Psychiatric Medication Expenditures (June 2020-May 2021)



Source: RIDOC data presented in The State of Behavioral Healthcare In Rhode Island: 2020 Report.[85]

[iv] These data reflect individuals in Rhode Island correctional facilities; they do not include forensic clients at the Rhode Island State Psychiatric Hospital.

RIDOC's Transitional Services and Discharge Planning department works internally to support individuals preparing to transition back to the community. This includes providing resources; referrals to mental health, medical, and SUD treatment providers; and assistance accessing, for example, Medicaid coverage and/or identification documents. However, the department has capacity to serve only a small portion of the CCBHC populations, with support for those awaiting trial being particularly limited due to the unpredictable timeframes involved. Additionally, while RIDOC contracts with an outside organization to provide MAT services both during incarceration and transition into the community, no comparable relationship currently exists for other types of behavioral health services, and the Transitional Services department is not able to conduct warm handoffs to community-based providers.

4.1.1. Depression and Self-Reported Mental Health

Available data also sheds light on Rhode Islanders' self-reported experiences of depression, depressive symptoms, and overall mental health.

Adults: The Rhode Island Behavioral Risk Factor Surveillance System (RI BRFSS)[86] found that the percentage of adults (age 18+) reporting that a health professional told them they had depression were fairly similar from 2017 (229.5 per 1,000) to 2021 (232.1 per 1,000). Veterans were less likely than non-veterans to report that this had happened (16.7% vs 22.2%). In contrast, average rates of depression mentioned by a health professional were higher among those who did not complete high school (29.9%) compared to those who completed high school (22.1%) or more than high school (19.7%). They were also higher among those with lower incomes (33.6% among those earning $25,000 or less vs 15.6% among those earning $75,000+), with a clear decreasing trend as income category rose. Rates were also higher among:

- Those with Medicaid (41.0%) compared to those with Medicare (24.1%), private insurance (18.0%), or no health insurance (14.8%);
- Those who identified as female versus male (259.8 vs 157.2 per 1,000);
- Those who identified as having a disability compared to those who did not (43.4% vs 14.0%); and
- Those who identified as LGBTQ versus those who did not (26.4% vs 12.7%).

Looking at race and ethnicity, on average across 2017-2021, rates of depression mentioned by a health professional were highest among non-Hispanic White individuals (212.5 per 1,000) and Hispanic individuals (206.0 per 1,000), with rates among non-Hispanic Black individuals (152.0 per 1,000) and non-Hispanic individuals of other races (183.1 per 1,000) being somewhat lower. However, the RI BRFSS also measured the percentage of adults who reported poor mental health for 14 or more of the past 30 days (for 2021, the rate was 140.8 reports per 1,000 adults), and this told a different story. On average across 2017-2021, non-Hispanic individuals of "other" races experienced frequent poor mental health at the highest rates (141.6 per 1,000), followed by Hispanic (129.5 per 1,000) and non-Hispanic Black (126.3 per 1,000) individuals. Non-Hispanic White individuals had the lowest rates (99.53 per 1,000). While poor mental health can certainly be related to conditions other than depression, this suggests that non-Hispanic White individuals may be more likely to receive a professional diagnosis when experiencing mental health distress. (Patterns of frequent poor mental health across other demographic groups matched those for depression mentioned by a health professional.)

Youth: Among middle- and high-schoolers, the 2021 Rhode Island Youth Risk Behavior Survey (YRBS)[87] found that 38% of high schoolers reported feeling sad or hopeless almost every day for at least two

weeks in a row, such that they stopped doing some of their usual activities, within the past 12 months. Additionally, 24% of middle schoolers reported that their mental health, including stress, anxiety, and depression, was not good most of the time or always in the past 30 days. Compared to those who identified as male, those who identified as female had higher rates of self-reported poor mental health (high school: 5.0 vs 2.6 per 1,000; middle school: 3.1 vs 1.3 per 1,000). Rates of self-reported poor mental health were highest among non-Hispanic Black individuals (high school: 6.9 per 1,000; middle school: 2.3 per 1,000) and Hispanic or Latino individuals (6.2 and 3.3 per 1,000). Non-Hispanic multiracial (4.2 and 2.4 per 1,000) and non-Hispanic Asian (4.1 and 2.9 per 1,000) respondents had the next highest rates, while non-Hispanic White individuals had the lowest (2.4 and 1.7 per 1,000). In Providence, a 2020 assessment of public school students' health needs noted that an estimated 80-90% of students had experienced trauma.[88]

4.1.2. Suicide Fatalities, Attempts, and Ideation

In 2021, 10.7 per 100,000 Rhode Islanders died by suicide; this rate was one of the lowest in the country, with Rhode Island ranking 45th out of 51 states (including the District of Columbia).[89] The number of suicides occurring in Rhode Island has remained consistent overall for the past decade, with a slight decrease in 2020.[90] During the years 2017 to 2021, Rhode Island Violent Death Reporting System (RIVDRS) data show that, on average, 118 suicide fatalities occurred in Rhode Island overall each year, amounting to a rate of 10.8 suicide fatalities per 100,000 residents.[91] These rates varied across CCBHC regions (Table 7), with the Pawtucket region having the lowest rate of suicide deaths (8.0 per 100,000) and the Washington and Newport regions having the highest rates (14.6 and 14.0 per 100,000).

Table 7. Suicide Fatalities by CCBHC Region, 2017-2021

	Average Annual Suicide Fatalities	Rate per 100,000
Northern RI	12.6	9.7
Pawtucket Region	7.8	8.0
Providence Region	17.4	9.2
Johnston/West	22.4	11.6
Kent Region	17.6	10.4
Washington Region	19	14.6
Bristol/East Bay	8.8	9.0
Newport Region	12	14.0
Rhode Island Overall	117.6	10.8

Source: Rhode Island Violent Death Reporting System

In the state as a whole, suicide fatalities were disproportionately common among people aged 55 to 64, who made up 22% of deaths in the years 2016-2020 despite accounting for only 12% of the population. In contrast, individuals under age 25 accounted for 33% of the Rhode Island population during those years, but only 9% of suicide deaths.[90] RIVDRS data for 2017-2021 show that men died of suicide more often than women, at an average annual rate of 17 compared to 5 per 100,000. Non-Hispanic White individuals also died of suicide at higher rates (13 per 100,000) than non-Hispanic Black individuals (7 per 100,000) or Hispanic or Latino individuals (6 per 100,000).[91] Other analyses have found that this remains true when adjusting for age, though the gap between non-Hispanic White and Hispanic individuals becomes smaller.[90]

Suicide attempts: The 2019-2020 NSDUH found that among Rhode Island adults older than 25, the attempted suicide rate was 0.5%, higher than the national average of 0.3%; Rhode Island is the only Northeastern state for which this is the case.[92] For individuals aged 18-25, the 2022 Rhode Island Young Adult Survey (RIYAS)[93] found that of 3% of participants had attempted suicide, with the percentage being substantially higher (13%) among veterans. For middle and high school students, the YRBS[87] found that 10% of high school respondents and 9% of middle school respondents had attempted suicide in the

past year. Rates were higher among those who identified as female rather than male (high school: 1.06 vs 0.64 per 1,000; middle school: 1.15 vs 0.62 per 1,000). Rates were also higher among non-Hispanic Black individuals (high school: 1.73 per 1,000; middle school: 1.65 per 1,000) and Hispanic or Latino individuals (1.52 and 1.49 per 1,000), followed by non-Hispanic multiracial individuals (1.06 and 1.13 per 1,000), non-Hispanic Asian individuals (0.86 and 1.09 per 1,000), and finally non-Hispanic White individuals (0.49 and 0.54 per 1,000).

Suicidal ideation: The 2021 NSDUH indicated that 4.7% of Rhode Island adults had seriously considered suicide in the past year, and 1.6% had made a suicide plan.[82] Among those aged 18-25, the RIYAS found that in the past year, 15% had considered suicide and 8% had made a suicide plan.[93] Individuals who had a disability more often reported having considered suicide (28%), as did those who identified as being part of a sexual or gender minority (24%). Reports of having considered suicide were also more common among individuals who identified as Hispanic (18%) or multiracial/"some other race" (19%). Among YRBS respondents, 17% of high schoolers and 23% of middle schoolers had seriously considered suicide in the past year.[87] As with youth suicide attempts, rates were higher among females than males (high school: 2.32 vs 1.08 per 1,000; middle school: 2.91 vs 1.34 per 1,000). When looking at race and ethnicity, Hispanic or Latino respondents (high school: 2.81 per 1,000; middle school: 3.69 per 1,000) and non-Hispanic Black respondents (2.66 and 2.87 per 1,000) again had the highest rates, followed by non-Hispanic Asian individuals (2.11 and 2.71 per 1,000) and non-Hispanic multiracial individuals (1.83 and 2.48 per 1,000). Non-Hispanic White respondents had the lowest rates (1.09 and 1.45 per 1,000).

4.2. Substance Use

Rhode Islanders ages 14 and older consumed alcohol at the 17th highest rate in the country in 2020.[94] Based on Rhode Island hospital discharge reports,[84] alcohol-related disorders were the fourth most common diagnoses for hospitalizations by 2022. Hospitalizations related to opioid use (and other drug use) were much less common than hospitalizations related to alcohol. In 2022, there were 5,309 hospital discharges with alcohol/drug use and alcohol-/drug-induced organic mental disorders as major diagnoses, or 4.85 per 1,000 Rhode Islanders. Rates were higher among males than females (7.1 vs 2.7 per 1,000); among non-Hispanic Black (7.0 per 1,000) and non-Hispanic White (5.3 per 1,000) individuals than Hispanic individuals (3.7 per 1,000) or non-Hispanic individuals of "other" races (1.4 per 1,000); and among people aged 35-64 (6.7 per 1,000) and 25-34 (4.4 per 1,000) compared to other age groups. BHOLD data suggest that in 2022, approximately 12 out of every 1,000 Rhode Islanders received substance use services from BHDDH-licensed providers.[81] The 2021 NSDUH estimated that 18.1% of Rhode Island adults and 8.5% of Rhode Islanders ages 12-17 needed but did not receive treatment for an SUD in the past year.[82]

4.2.1. Alcohol Use

Adults: For Rhode Island adults (age 18+), alcohol use in 2020 did not significantly exceed the US average (58% versus 52% of respondents).[94] Reports from this age group on the RI BRFSS indicate that past-month alcohol use decreased from 2017 (565 reports per 1,000 adults) to 2021 (541 per 1,000),[86] but hospital discharge data suggest that use of alcohol and drugs increased again in 2022 (see Table D7 in Appendix D). Binge drinking among adults (reported by 17.3% of Rhode Island adults in 2021) appears to have followed a similar pattern.[86]

For Rhode Island as a whole, average reports of past-month alcohol use across 2017-2021 were higher among non-Hispanic White individuals (569.30 reports per 1,000) than among non-Hispanic Black

individuals (417.53 per 1,000), Hispanic individuals (417.34 per 1,000), or non-Hispanic individuals of other races (434.28 per 1,000). Average rates were also higher among those who identified as male versus female (575.11 vs 510.15 per 1,000), as not having a disability versus having a disability (64.9% vs 47.5%), as being a veteran versus not (65.4% vs 59.5%), and as being LGBTQ versus not (62.8% vs 60.8%). Average reports were also higher among:

- Those who completed more than high school (68.8%) compared to those who did not complete high school (35.8%) or completed only high school (51.9%);
- Those with higher household incomes ($75,000+: 75.7%; $25,000 or less: 40.1%); and
- Those with private health insurance (69.3%) compared to those on Medicare (51.8%), no insurance (51.4%), or Medicaid (43.3%).

Binge drinking across population groups followed a similar pattern, except that rates of binge drinking were higher among non-veterans than veterans (17.2% vs 15.3%).

Youth and Young Adults: NSDUH reports indicate that 12- to 20-year-old Rhode Islanders consistently drank more than the national average in both 2015-2016 (24.9% vs 19.8%) and 2019-2020 (22.9% vs 17.3%).[92] This group also consistently reported more binge drinking than the US average during those time periods (2015-2016: 16.0% vs 12.7%; 2019-2020: 12.4% vs 10.1%). In 2019-2020, 2.8% of Rhode Island 12- to 17-year-olds, 17.9% of 18- to 25-year-olds, and 11.4% of adults older than 25 reported needing but not receiving treatment for DSM-V Alcohol Use Disorder. These rates particularly highlight a gap for 18- to 25-year-olds, whose reported need exceeds the national average (17.9% vs 15.2%).

For Rhode Island young adults (ages 18-25), the RIYAS found that 60% reported drinking alcohol in the past month, 16% reported hazardous drinking, and 6% met criteria for AUD.[93] Drinking within the past month was higher among young adults who identified as being a part of a sexual or gender minority (65%). Among those who reported ever drinking, 17 years old was the average age of having their first drink. Of those who were underage, 38% drank within the past month, with those who identified as White being particularly likely to have done so (45%). Cisgender heterosexual men were more likely to meet criteria for AUD than cisgender heterosexual women (10% vs 4%).

For Rhode Island middle- and high-school students, the 2021 YRBS found that 17.2% of high school respondents reported drinking alcohol within the past 30 days.[87] Rates were slightly higher for female than male students (1.78 vs 1.43 per 1,000), and were higher for non-Hispanic Asian (1.87 per 1,000), non-Hispanic Black (1.65 per 1,000), Hispanic/Latino (1.91 per 1,000), and non-Hispanic multiracial (2.04 per 1,000) individuals compared to non-Hispanic White individuals (1.27 per 1,000). Among middle school students, 11.6% of respondents reported drinking alcohol; differences across groups were similar to high school patterns.

4.2.2. Drug Use

Adults: The 2021 NSDUH estimated that 20.5% of Rhode Island adults had used illicit drugs[v] in the past month.[82] Marijuana was the most common illicit drug used in the past month (18.2%), while 4.5% of adults had used an illicit drug other than marijuana. Additionally, in the past year, 3.6% of Rhode Island

[v] In NSDUH reports, this includes "the misuse of prescription psychotherapeutics or the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine."

adults had misused opiates,[vi] 2.3% had used cocaine, 0.8% had used methamphetamine, and 0.5% had used heroin. Approximately 10.3% of adults met criteria for a drug use disorder, 2.2% met criteria for an OUD, and 8.4% were classified as needing but not receiving treatment for illicit drug use.

Youth and Young Adults: The RIYAS found that 18% of young adults (ages 18-25) reported having engaged in hazardous cannabis use, 7% in ever using hallucinogens, and 4% in ever using cocaine.[93] Individuals who identified as a sexual or gender minority were more likely to have engaged in hazardous cannabis use (26%) and used hallucinogens (10%); those with a disability were more likely to have engaged in hazardous cannabis use (27%), used hallucinogens (10%), and used cocaine (7%). Hallucinogen use was also higher among those who were students (6%). Respondents were less likely to have used cocaine if they identified as a cisgender heterosexual female (3%) and more likely if they were a student (3%) or were employed (5%).

For Rhode Islanders aged 12-17, the 2021 NSDUH estimated that 11.0% had used illicit drugs in the past month.[82] As for adults, marijuana was the most commonly used (9.7% had used it in the past month), while 2.3% had used an illicit drug other than marijuana in the past month. Rates of cocaine, heroin, and methamphetamine use in this age group were not available, but 2% had misused opioids (largely prescription painkillers) in the past year. An estimated 0.8% met criteria for OUD.

Overall: Data provided by Prevent Overdose RI indicate that in 2022, 21,316 Rhode Islanders (or 20 per 1,000) were receiving buprenorphine and 24,022 (or 22 per 1,000) were receiving methadone.[95] Non-Hispanic White individuals received methadone at substantially higher rates than other groups, at 650 per 100,000, compared to 335 per 100,000 for Hispanic individuals and 281 per 100,000 for non-Hispanic Black individuals.[96] See Tables D9 and D10 in Appendix D for more information, including change over time.

4.2.3. Overdose Fatalities

In 2022, approximately 436 people in Rhode Island died of overdose (Table 8), or approximately 40 out of 100,000. This rate varied across counties, with Providence County having the highest rate (42 fatal overdoses per 100,000 residents). Kent County had the second-highest fatal overdose rate (34 per 100,000), but was nevertheless below the overall state rate, while Bristol, Washington, and Newport Counties all had fatal overdose rates below 25 per 100,000 residents.

Looking at Rhode Island overall, overdose fatality rates increased sharply from 2019 to 2020, and continued to increase at a slower pace in 2021 and 2022.[97] Notably, in 2022, the vast majority (71%) of individuals who died of overdoses involving opioids had no known history of substance use treatment, and half (51%) had no known mental health treatment history.

[vi] NSDUH defines this as "using heroin or misusing prescription pain relievers."

Table 8. Fatal Overdoses in Rhode Island by County, 2022

	Providence County	Kent County	Bristol County	Washington County	Newport County	Rhode Island Overall
Total Fatal Overdoses	278	59	10	28	19	436
Fatal Overdoses per 100,000	42.3	34.4	19.7	21.5	22.5	39.9
Age						
24 or younger	19 (7%)	— (5%)	0 (0%)	0 (0%)	0 (0%)	23 (5%)
25-34	53 (19%)	11 (19%)	—	13 (46%)	— (11%)	92 (21%)
35-44	69 (25%)	16 (27%)	—	5 (18%)	5 (26%)	106 (24%)
45-54	63 (23%)	11 (19%)	—	— (14%)	5 (26%)	95 (22%)
55 or older	74 (27%)	18 (31%)	—	6 (21%)	7 (37%)	120 (28%)
Gender						
Female	76 (27%)	14 (24%)	— (30%)	7 (25%)	8 (42%)	121 (28%)
Male	201 (72%)	45 (76%)	7 (70%)	21 (75%)	11 (58%)	314 (72%)
Contributing Substances						
Opioid	235 (85%)	49 (83%)	5 (50%)	23 (82%)	15 (79%)	358 (82%)
Fentanyl	214 (77%)	42 (71%)	—	22 (79%)	14 (74%)	323 (74%)
Cocaine	149 (54%)	28 (47%)	—	14 (50%)	— (—)	219 (50%)
Alcohol	68 (24%)	18 (31%)	—	5 (18%)	7 (37%)	110 (25%)
Substance Use Treatment History (Opioid-Involved Overdoses)*						
No known treatment	72%	71%	100%	55%	60%	71%
Current treatment	17%	17%	0%	—	—	17%
Past treatment	10%	13%	0%	32%	—	13%
Mental Health Treatment History (Opioid-Involved Overdoses)*						
No known treatment	54%	44%	100%	36%	33%	51%
Current treatment	39%	46%	0%	55%	67%	42%
Past treatment	7%	10%	0%	—	0%	7%

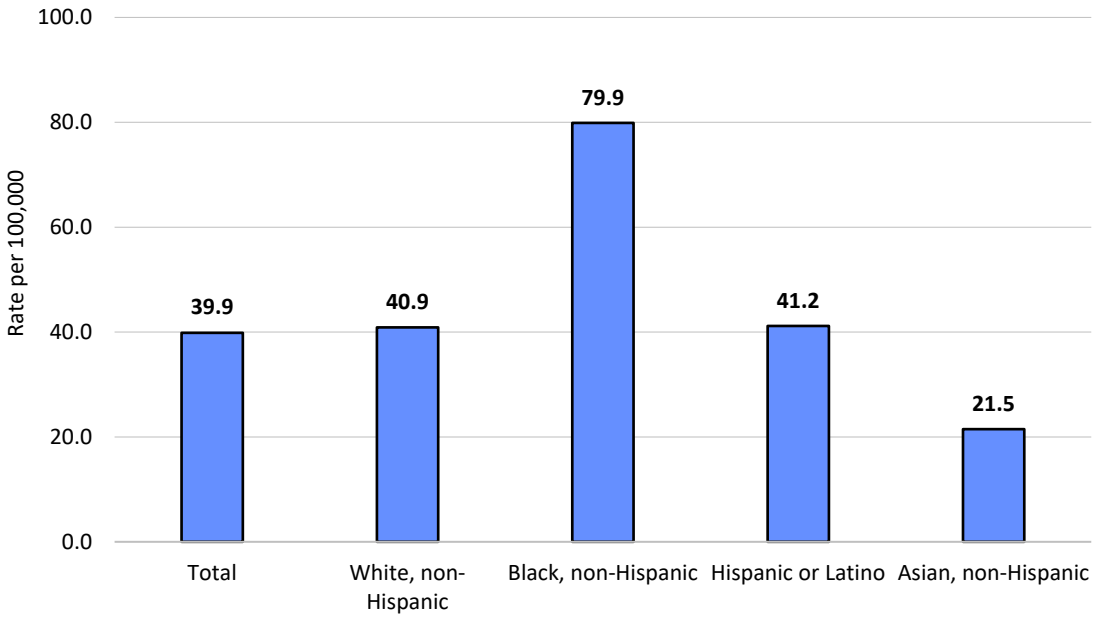
Source: Office of the State Medical Examiners Fatality Data,[98] except where otherwise noted. Location is based on place of occurrence; fatal overdoses with unknown location or unknown race and ethnicity are excluded.

** Source: State Unintentional Drug Overdose Reporting System Fatality Data.[99] Data are limited to fatal overdoses that involved opioids and that were either accidental or of undetermined intent; substance use treatment history additionally excludes individuals without known substance use history.*

There were also clear disparities in overdose fatalities by race and ethnicity (Figure 5). Non-Hispanic Black individuals died of overdoses at the highest rate, with approximately 80 overdose deaths per 100,000. Hispanic or Latino individuals and Non-Hispanic White individuals died of overdoses the second-most often, but at substantially lower rates (41 per 100,000 for both groups).[98] Additionally, overdose death rates among Hispanic or Latino individuals increased by 50% from 2021 to 2022.[96,vii] Men also died of overdoses more often than women (59 vs 22 per 100,000) and individuals aged 25 to 34 died more often (61 per 100,000) than those who were younger (7 per 100,000) or older (51 per 100,000).[97]

[vii] Note that population rates listed by Prevent Overdose RI differ from those presented here due as a result of differing denominator estimates. This analysis uses ACS estimates because they are available at the municipal level, while Prevent Overdose RI uses estimates available through CDC WONDER.

Figure 5. Rhode Island Drug Overdose Fatality Rate by Race and Ethnicity, 2022



Source: Office of the State Medical Examiners Fatality Data[98]

4.3. Summary of Health System Findings

Data presented above show that substantial behavioral health needs exist across Rhode Island, with Providence County facing particularly high challenges in terms of fatal overdose rates and the Washington and Newport regions facing higher suicide rates. Disparities were also visible across a range of groups, with those who had lower incomes, had a disability, or were LGBTQ often having worse behavioral health outcomes. Disparities by race and ethnicity were also notable; while non-Hispanic White individuals died by suicide more often than other groups, many other measures showed worse outcomes for other racial and ethnic groups. This was particularly marked when looking at overdose fatality rates, but was also visible in areas such as self-reported mental health and suicidal ideation. There is also evidence that individuals from historically marginalized racial and ethnic groups may have higher unmet treatment needs; for example, Hispanic or Latino and Black individuals received methadone treatment at lower rates than non-Hispanic White individuals, and were more likely than non-Hispanic Whites to report poor mental health but less likely to have received a depression diagnosis. These factors represent both health and wellbeing outcomes and intermediate determinants of health on the Equity Conceptual Model (Figure 2).

5. Synthesis of Findings

This section synthesizes the secondary data discussed above with the primary data collected as part of this needs assessment. Primary data reflected the perspectives of two main groups: individuals with lived and living experience of mental health and/or substance use challenges and staff members who work directly with the aspiring CCBHCs' five priority populations. (As discussed in Section 1.1, these populations are individuals with SMI, individuals with SUDs, children and adolescents with SED,

individuals with co-occurring SUD and mental health conditions, and individuals experiencing a behavioral health crisis.)

Staff perspectives were gathered via an online survey. Participants (referred to in this section as "respondents"; n=498) were staff at aspiring CCBHCs, as well as staff at community organizations identified by SAMHSA's 2023 CCBHC requirements as key care coordination partners (approximately 150 unique organizations). Although the surveys are confidential, each respondent provided their name, email address, and phone number, making it possible for the evaluation team to drill down further to understand issues and concerns in more depth.

The perspectives of people with lived and living experience were gathered through interviews with individuals currently engaged with support and services (n=72) and individuals not engaged (n=29). The evaluation team also had the opportunity to gather additional perspectives from community members who volunteer with the five key CCBHC population groups. Within this section, interview participants are referred to as "individuals."

The primary data strongly align with secondary data analyzed and much of the information gathered via existing reports. Areas of congruency are integrated in this section, meaning that some of the information presented above is summarized again here. Findings without comparable data from secondary sources or existing reports are also highlighted throughout this section.

5.1. Populations and Individuals Needing the Most Help

Survey respondents were asked to identify the groups that they believed needed the most help (Table 9), based on their personal experiences working with the CCBHC populations. (For a chart illustrating all responses to this question at the state level, see Figure D2 in Appendix D.) This data was combined with interviews and other primary data to identify groups particularly in need of services and support.

Table 9. Groups Needing the Most Help, by CCBHC Region

	Providence Region (n=206)	Pawtucket Region (n=118)	Northern RI (n=144)	Johnston/ West (n=104)	Bristol/ East Bay (n=108)	Kent Region (n=119)	Washington Region (n=105)	Newport Region (n=124)
Age								
Children	37.4%	35.6%	41.7%	35.6%	31.5%	39.5%	41.9%	32.3%
Transition age (18-25)	40.3%	38.1%	34.7%	32.7%	34.3%	37.0%	31.4%	30.6%
Aging/elderly	34.5%	33.1%	31.3%	33.7%	32.4%	36.1%	34.3%	32.3%
Race & Ethnicity								
Black	50.5%	44.1%	36.8%	37.5%	30.6%	37.0%	26.7%	32.3%
Latino/x	42.7%	34.7%	28.5%	26.9%	21.3%	26.1%	16.2%	25.0%
Indigenous American	21.8%	15.3%	13.2%	12.5%	13.0%	16.0%	12.4%	12.9%
Asian/Pacific Islander	19.4%	12.7%	16.0%	13.5%	12.0%	12.6%	10.5%	11.3%
Other people of color	35.0%	29.7%	25.7%	23.1%	22.2%	21.8%	15.2%	22.6%
Circumstances								
Mental health concerns	81.1%	85.6%	85.4%	79.8%	80.6%	82.4%	79.0%	82.3%
Low-income	76.2%	75.4%	78.5%	71.2%	72.2%	73.9%	68.6%	72.6%
Homeless	71.4%	70.3%	68.1%	67.3%	71.3%	68.9%	61.9%	67.7%
SUDs	68.9%	69.5%	68.1%	65.4%	61.1%	64.7%	60.0%	60.5%
Justice system-involved	48.1%	41.5%	33.3%	36.5%	34.3%	40.3%	32.4%	33.9%

	Providence Region (n=206)	Pawtucket Region (n=118)	Northern RI (n=144)	Johnston/ West (n=104)	Bristol/ East Bay (n=108)	Kent Region (n=119)	Washington Region (n=105)	Newport Region (n=124)
Un-/underinsured	47.1%	46.6%	43.1%	39.4%	44.4%	42.9%	40.0%	37.1%
Domestic violence	49.5%	50.0%	45.1%	46.2%	45.4%	46.2%	36.2%	44.4%
LGBTQ	44.7%	40.7%	39.6%	32.7%	28.7%	35.3%	23.8%	26.6%
Individuals with I/DD*	42.2%	42.4%	39.6%	34.6%	31.5%	40.3%	30.5%	29.8%

** I/DD: Intellectual and/or developmental disabilities*

Note: Percentages reflect the proportion of survey respondents who selected the listed group when asked, "In your perspective, which individuals need the most help in your region? (Select all that apply.)" Red highlighting indicates the highest percentage across all regions.

5.1.1. Race and Ethnicity

In Rhode Island overall, non-Hispanic Black individuals were identified as one of the groups needing the most help (Figure 6). This remained true across individual CCBHC regions, with respondents selecting this group as "needing the most help" more often than they selected any other listed racial or ethnic group. Specific rates varied across regions, with the highest rates in the Providence and Pawtucket regions and the lowest in Washington. The non-Hispanic Black population faces numerous inequities, as identified in the secondary data. Examples of these inequities (also presented above) include:

- In Rhode Island, the rate of homelessness for Black individuals (of any ethnicity) on a single night in 2021 was 80 out of 10,000, while the rate for White individuals (of any ethnicity) was 10 out of 10,000.
- For criminal legal system involvement in Rhode Island, Black individuals make up 24% of commitments, 28% of those awaiting trial, and 40% of those sentenced, despite being less than 10% of the state's population.
- Black individuals died of overdoses at the highest rate compared to other racial and ethnic groups, with approximately 80 overdose deaths per 100,000 in Rhode Island overall.

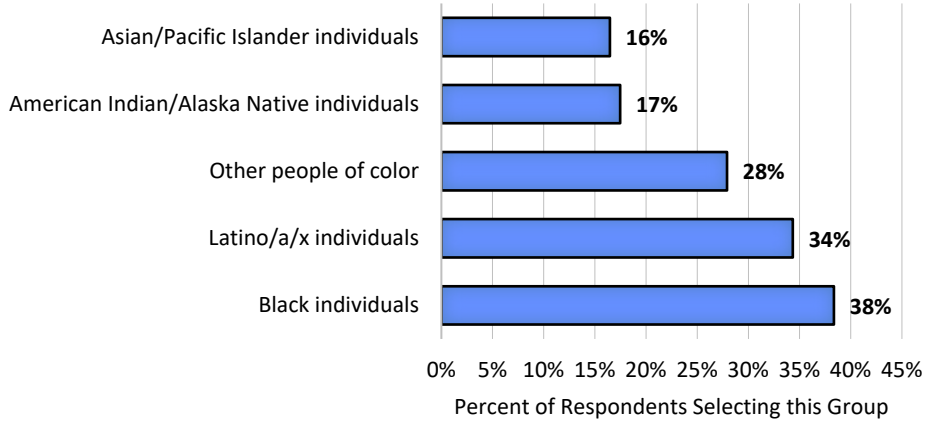
The second racial or ethnic group identified as needing the most help were Hispanic and Latino individuals. Again, this was consistent across regions, but with the highest rate in Providence and the lowest in Washington. Respondents who elaborated on this topic reported that most Hispanic and Latino people they work with are facing multiple issues, such as battling addiction, homelessness, and depression. For example, one person described their work with a client, saying, "So many times, I have attempted to connect him with services and cannot because of the lack of Spanish-speaking providers." Individuals reported similar circumstances, as well as shame regarding losing their family connections. One person shared, "I cannot ask my family for anything—they would do anything for me—I am heartbroken—ashamed." Secondary data also revealed similar disparities for Hispanic individuals as those described for Black individuals. For example:

- On a single night in 2021, 16 out of 10,000 Hispanic or Latino individuals were experiencing homelessness, compared to 11 out of 10,000 individuals who were not Hispanic or Latino.
- Hispanic individuals make up 16% of Rhode Island's population, but 21% of commitments, 27% of those awaiting trial, and 26% of those sentenced.

Survey respondents selected Indigenous individuals and Asian and Pacific Islander individuals at similar rates when asked about groups needing the most help; both were chosen less often than non-Hispanic Black or Hispanic or Latino individuals, but by a notable percentage of respondents. Again, Providence

had the highest percentages for both populations and the Washington region had the lowest. While secondary data are available for Indigenous Americans on the national level, comparatively little information is available on the state level; however, Indigenous individuals did participate in interviews, sharing insightful comments that are integrated throughout this synthesis. Regarding Asian and Pacific Islander individuals, respondents who elaborated on this group mainly focused on language barriers and their perception that many individuals were uncomfortable using translation services. Providers who work directly with this group reported that trust issues are a common challenge and, if a provider cannot at least speak the person's language, it will be hard to assess and address their needs.

Figure 6. Groups Needing the Most Help: Race and Ethnicity



5.1.2. Age

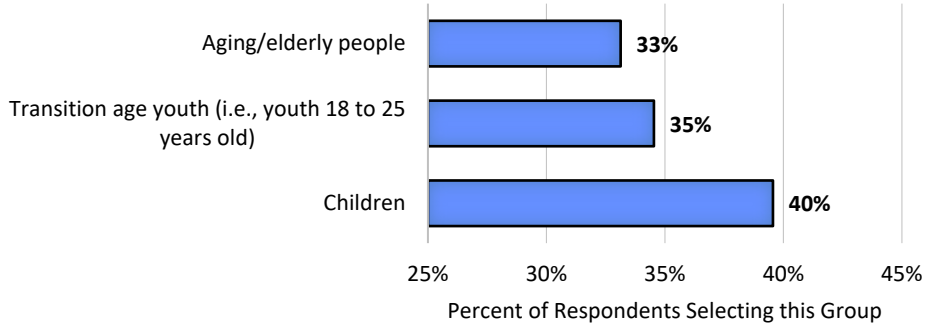
In terms of age groups (Figure 7), children were viewed as requiring the most help within Rhode Island overall. This group was also ranked highly across regions, with the highest rates in Washington and Northern RI and the lowest in Bristol/East Bay and Newport. Several respondents specifically noted children under three as needing particular help, reporting a lack of options for parents and young children with significant needs. Providers reported that for very young children, options in the state are limited. School-age children present similar difficulties. Parents reported challenges getting help within the school system; for example, one person shared, "My daughter has suicidal ideation and outbursts in school. There is no one there to help her." School staff supported this viewpoint. Respondents from high-needs regions reported that there was a strong need for mental health and substance use services in schools, and that help with the SED population was particularly pressing.

Transition-age youth (those aged 18-25) also made the list of groups needing support and services. Providers and survey respondents both expressed concern for this group; among survey respondents, concerns were highest in Providence and lowest in Newport and Washington, but existed across all regions. Frequently, these concerns centered around the stigma associated with seeking support and services. Many of the engaged and non-engaged individuals interviewed reported that they did not know about support and assistance opportunities and were not optimistic about these options. As one individual put it, "the streets—better than being at home." A Spanish-speaking volunteer who frequents some of the high-need areas in Providence remarked, "Why are there so many young people just hanging around—doing drugs or whatever—where are their families?" This is congruent with secondary data findings, which noted substantial challenges for young people in the time leading up to transitional

age. As identified by the YRBS,[87] within the past year, 38% of Rhode Island high schoolers reported feeling sad or hopeless almost every day for at least two weeks in a row, such that they stopped doing some of their usual activities; in addition, 17% had seriously considered suicide, and 10% had attempted suicide. On the Rhode Island Student Survey (RISS), which did not include Providence, 39% of high school respondents reported being made fun of in 2022;[100] on the Providence Public School District's Youth Experience Survey, only 33% of respondents reported enjoying being in school, 28% reported not feeling safe in school, 47% reported being teased, and 21% reported being cyber bullied.[101] Respondents working in schools expressed the dire need for mental health and addiction services.

Individuals who are aging or elderly were also noted as requiring support and services, with relatively similar rates of agreement across all regions. Importantly, challenges facing this group affect not only aging individuals themselves, but also others who are acting as caregivers. Individuals shared their struggles with balancing the demands of their own lives while "taking care of mom." Struggles are compounded when the caregiver is working multiple jobs and raising children. Resources and help are limited. As one person remarked, "I can't get an aide for my mom even if I could afford it."

Figure 7. Groups Needing the Most Help: Age



5.1.3. Circumstances

Individuals needing the most help were also examined by specific circumstances. In Rhode Island overall, individuals with low incomes were noted as a group facing concerns; rates of agreement were highest in Northern RI and Providence and lowest in Washington, but relatively high across all regions. Respondents pointed out that those struggling with low incomes are very vulnerable to becoming homeless or increasing their involvement with the criminal legal system. Low-income individuals, even if they work two jobs, cannot "make ends meet." As one individual shared, "I lost my apartment when I lost my job… I have been on the streets for two years." Another participant pointed out, "I can't get a place or a job… was incarcerated for two years." Secondary data and existing reports strongly align with these findings. As noted above, the challenges associated with SMI and/or SUD can make poverty or unemployment more likely,[27] while social and economic challenges and associated structural barriers also affect individuals' risk of developing SMI or SUD, their likelihood of experiencing more severe forms of these conditions, and their ability to access treatment and recovery.[27-30] It is also clear that poverty is a particular challenge in areas such as the Providence and Pawtucket regions, which have poverty rates above that of the state overall (22% in Providence and 17% in the Pawtucket region vs 11% in Rhode Island) and are situated in the county with the highest food insecurity rate. According to the Massachusetts Institute of Technology (MIT) living wage calculator, one adult with no children would need an annual wage of $36,443 to live in Rhode Island.[73] Many industries, such as accommodation and

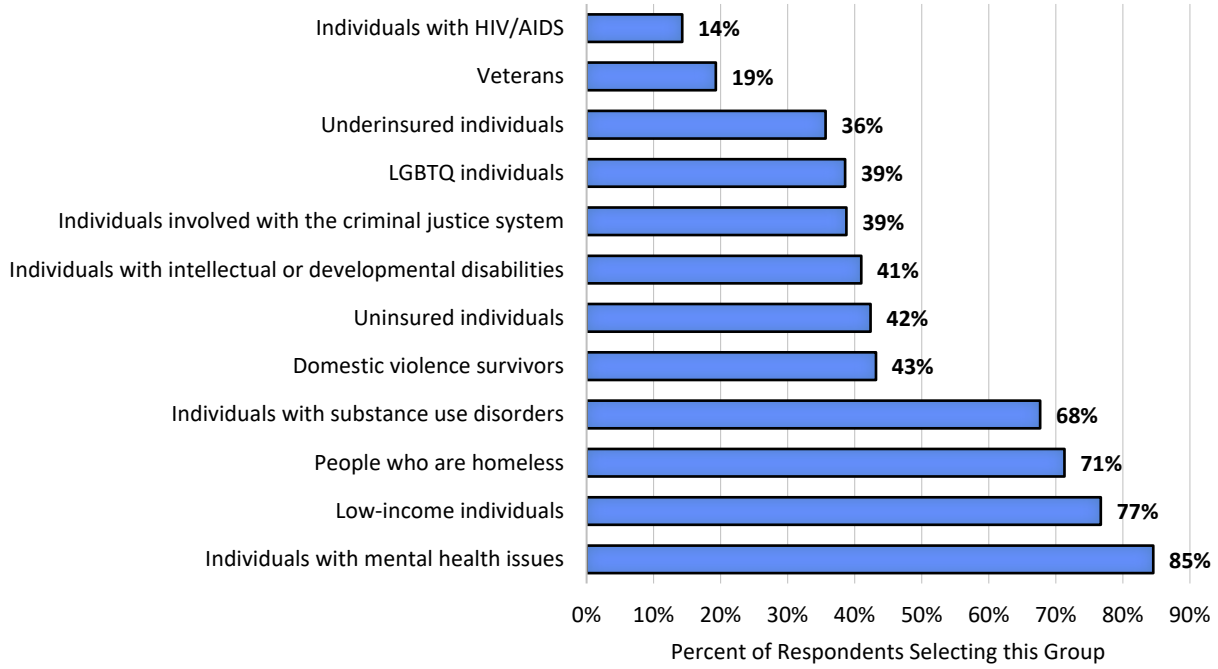
food services, pay below this living wage. Several survey respondents themselves reported not making a living wage and working two jobs.

Individuals with mental health challenges (similar rates of concern across all regions), those without a home (highest rates of concern in Providence, Bristol/East Bay, and Pawtucket; lowest in Washington), and individuals with SUD (highest rates in Pawtucket, Providence, and Northern RI; lowest in Newport and Washington) also received recognition from survey respondents as requiring help. Respondents pointed out, "I see many people who need help and are too sick (SMI/SUDs) to advocate for themselves or something happens, and they can't fight the system." Interview participants had similar accounts: "I needed so much help. Here (aspiring CCBHC) someone helped me get an ID, food vouchers (SNAP), job training, and I am on the list for housing." Another individual shared, "I got help getting an appointment and hope I can get back on my medication soon (bipolar, homeless)."

Another group that was noted as particularly needing help was individuals in the criminal legal system, who emerged as a notable population on other measures as well. While this group appeared as an area of concern in all regions, rates were notably higher in Providence. Nationally, SMI is estimated to be three to five times more common and SUD to be six times more common among those incarcerated than among the general population.[21,22,24] In Rhode Island, a large portion of incarcerated individuals experience mental health challenges, with an average of 35.4% of inmates on psychiatric medications from 2017-2020. Data on RIDOC medication expenditures suggest that many of those incarcerated have mental health concerns related to the schizophrenia spectrum or other psychotic symptoms, and that some are also experiencing depression or anxiety symptoms. After incarceration, individuals reported being released to the streets with nowhere to go, no appointment to continue their addiction or psychotropic medication treatment, and no resources. One person shared, "I burned all my bridges. I got out with nothing—nowhere to go—took less than a week for me to be back in jail." Respondents reported a similar perspective, pointing out that "…someone who is released from prison who does not have a sober support network will not make it." Another respondent shared that after a decade in prison, he moved in with his girlfriend and her mother, noting, "They are so compassionate; believe this is why I am staying away from my old ways and continuing with treatment."

Finally, those who are under- or uninsured were also a consistent category of concern for respondents. Rates of concern regarding these groups were highest in the Providence and Pawtucket regions, both of which are situated in the county with the highest rates of uninsured individuals (3.6%) and individuals covered by Medicaid (33%). Despite being the county with the second-highest rates of uninsurance (3.3%) and Medicaid coverage (22%), Newport had the lowest percentage of respondents selecting this group as among those needing the most help; even so, however, over one-third of respondents in Newport expressed concern for this population. As one respondent observed, "Without good insurance, I cannot get them in anywhere." Respondents pointed out that Medicaid coverage does not meet the range of their clients' needs, and respondents working with older individuals reported that many important services that their clients need are not covered by Medicare. Individuals also voiced their concerns with coverage: "I finally have insurance (Medicaid); before that I could only go to the emergency room."

Figure 8. Groups Needing the Most Help: Other Groups and Circumstances



5.1.4. Other Groups

In addition to the categories presented above, other groups also arose as requiring services and support (Figure 8). These populations included survivors of domestic violence, who were also viewed as a high-need population; rates of concern for this group were highest in Pawtucket and Providence and lowest in Washington. Homelessness, mental health concerns, and addiction are directly related to domestic violence and have long-term effects on women and children.[102] (While women are not the only ones affected by domestic violence, they experience it more often[103] and were the primary focus of respondents and individuals who discussed this issue.) Many staff members pointed out that women they work with have long histories of being in abusive relationships. Providers viewed long and persistent trauma as a precursor to substance use, mental health concerns, homelessness, and involvement with the criminal legal system for both the victim and her children. As one individual shared, "Had to leave. He broke my arm—my ribs were cracked—he did go to jail but was released." She also shared that she lost her children and is now living on the street.

Individuals with intellectual and/or developmental disabilities (I/DD) also arose as a population of concern across regions, with the highest rates of agreement in Pawtucket and Providence and the lowest in Newport. This is a population that, nationally, is known to both have a higher risk of behavioral health conditions and to face substantial challenges in accessing appropriate, high-quality behavioral health care.[104] In addition, individuals identifying as LGBTQ were consistently identified as having unmet needs; however, specific rates varied substantially across regions, with the highest rate in Providence and the lowest in Washington. This matched the evidence available in secondary data, which showed that LGBTQ adults have higher rates of frequent poor mental health (26.4% vs 12.7%), having been told by a health professional that they had depression (26.4% vs 12.7%), and binge drinking in the past month (20.6% versus 16.7%). Among young adults (aged 18-25), individuals identifying as LGBTQ were

more likely to have seriously considered suicide (24% vs 15%), to have engaged in hazardous cannabis use (26% vs 18%), and to have ever used hallucinogens (10% vs 7%).

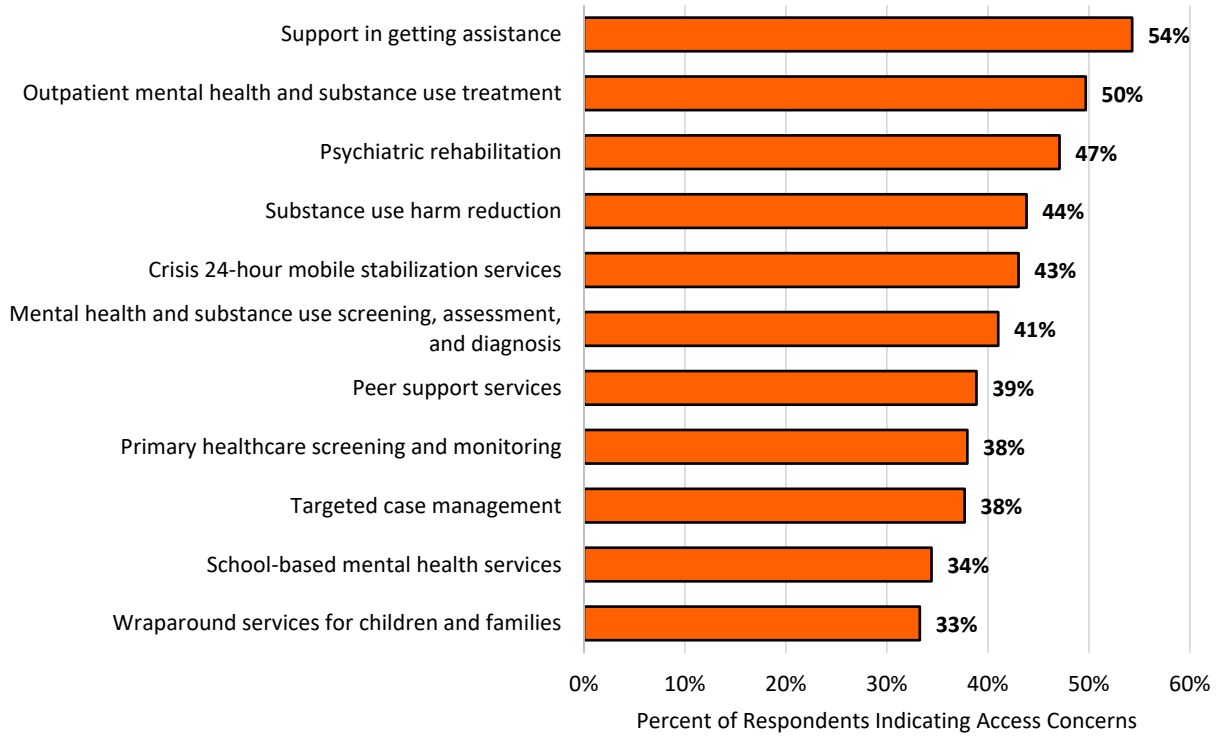
Finally, veterans were also identified by some respondents as a group needing support and services, with relatively consistent rates across regions. Respondents reported that, based on their experiences, there are clear needs for veterans. However, providers also noted some inconsistency in the range and type of services that veterans are eligible for; for example, one provider reported having more options for a long-term placement for a veteran than for other populations. This is consistent with secondary data, which also found high needs but some inconsistencies for the veteran population. Among individuals aged 18-25, veterans were substantially more likely to have attempted suicide (13% vs 3%), while among all Rhode Island adults, veterans were more likely to have drunk alcohol in the past month (65.4% vs 59.5%). However, veterans were less likely than Rhode Island adults overall to report past-month binge drinking, frequent poor mental health, or being told by a health professional that they had depression. Veterans have been added to the five CCBHC target populations, and aspiring CCBHCs are in the process of developing relationships with the VA and with specific organizations that provide support and services for veterans. They are also training their teams on military culture to assist staff with veteran outreach and engagement. In addition, each aspiring CCBHC is exploring, and some have already developed, specific outreach strategies such as hiring veterans as peer specialists and case managers. This newer CCBHC target population will require further assessment once relationships grow, supports and services are identified, and providers further develop their care coordination relationships.

5.2. Access to Support and Services

Survey respondents were asked to indicate whether they had concerns regarding individuals' ability to access a range of service types (Figure 9 and Table 10). Again, these responses were combined with other primary data to illuminate key gaps in service access.

Many survey respondents reported that those in need did not know how or where to get help. This concern was shared across regions, with the highest rates of agreement in Pawtucket and Kent and the lowest rates in Newport. This issue arose most often in regard to those being released from EDs, hospitals, and correctional facilities. One individual shared, "They let me out (prison)—had been there for over a year—nowhere to go really—back on the streets than back to jail." Another individual shared that he "had been in and out of jail—never had any help with getting treatment or a place to live." Another remarked, "I was on my meds in jail and then could not get them when I was released." Several other individuals recalled that they did not get help after a hospitalization or ED visit. For example, one individual remarked, "Been in the hospital for suicide attempts—a few times. Never had a place to go when I was released—they gave me a list of places to call—I don't have a phone." Aspiring CCBHCs and providers echoed these concerns. One aspiring CCBHC pointed out that their organization previously had a social worker who focused on individuals being released from prison, but the funding for that position was lost. Another reported a current issue with the ED in which, in their perception, an overwhelming volume of patients has led ED staff to increasingly "band-aid" patients and release them to the community without referrals, warm handoffs, or care coordination.

Figure 9. Access Concern Areas



Most survey respondents also reported persistent access barriers for both substance use and mental health services, with concern rates again highest in the Pawtucket region and lowest in Newport. Individuals' experiences echoed this. For example, one person shared, "I cannot get an appointment… have tried several times. Got one once and could not get there in time due to the buses. When I did, no one would talk to me—stopped trying." However, several individuals also reported situations where access did work well; for example, one person shared, "The people (FQHC) are getting me my medicine for depression. I am waiting for housing… Got a job." Several individuals also discussed how psychiatric rehabilitation was important for them, including noting that the "job training specifically led to a real job." However, nearly half of survey respondents indicated that they had concerns regarding people's ability to access psychiatric rehabilitation services, with concern rates highest in Pawtucket, Providence, and Washington. Most respondents who identified this as an access concern were focused on the availability of psychiatric rehabilitation options: "We need more options that get clients a job."

In addition to these overall concerns about substance use and mental health services, both survey respondents and individuals expressed concerns about the quality of such services, explaining that service quality directly affects individuals' ability to engage with a provider. As one respondent pointed out, "They (behavioral health providers) do not understand individuals who are struggling. Many had bad experiences in the past—one bad interaction can close a door for many years." Several individuals noted the importance of personal connection. As one person shared, "My peer counselor got me… he helped me."

Finally, crisis 24-hour mobile stabilization was also relatively high on the list of access concern areas; this was the case across regions, though the concern was expressed most frequently in Pawtucket,

Providence, and Washington. Providers did point out that things are improving in this area, with both jail and ED diversion programs and the centralized crisis response system for children and families. Providers also noted that many are reviewing ways to expand access to this specific service and ensure that closed-loop referral systems are in place. However, several individuals were unaware of crisis options. For example, one person remarked, "I just go to the ED and that is where other people take me… I can call somewhere?" A non-engaged, non-English-speaking individual revealed that they were unaware of the crisis number to call.

Table 10. Access Concern Areas, by CCBHC Region

	Providence Region	Pawtucket Region	Northern RI	Johnston/ West	Bristol/ East Bay	Kent Region	Washington Region	Newport Region
Support in getting assistance	59.5%	62.5%	53.8%	58.3%	57.7%	61.7%	55.3%	47.4%
Outpatient MH*/SUD treatment	55.6%	62.9%	50.0%	53.8%	58.1%	56.0%	57.7%	43.7%
Psychiatric rehabilitation	50.5%	53.2%	43.3%	44.7%	42.7%	42.1%	51.0%	43.6%
SUD harm reduction	48.2%	52.2%	43.0%	44.7%	46.6%	44.0%	51.5%	42.9%
Crisis 24-hour mobile stabilization services	47.0%	48.7%	43.4%	41.7%	41.3%	45.2%	48.1%	42.4%
MH/SUD screening, assessment & diagnosis	44.5%	48.3%	35.0%	43.7%	43.4%	45.6%	48.6%	37.2%
Peer support services	39.9%	46.4%	39.3%	36.0%	41.0%	38.9%	43.1%	44.0%
Primary health care screening & monitoring	37.9%	42.9%	35.2%	35.6%	37.9%	36.3%	34.3%	30.3%
Targeted case management	38.7%	43.5%	37.1%	34.6%	33.7%	35.7%	38.5%	28.2%
School-based mental health services	31.0%	36.3%	27.1%	24.5%	24.5%	28.9%	33.3%	31.8%
Wraparound services for children and families	28.4%	31.6%	25.4%	30.4%	30.4%	31.0%	34.3%	32.1%

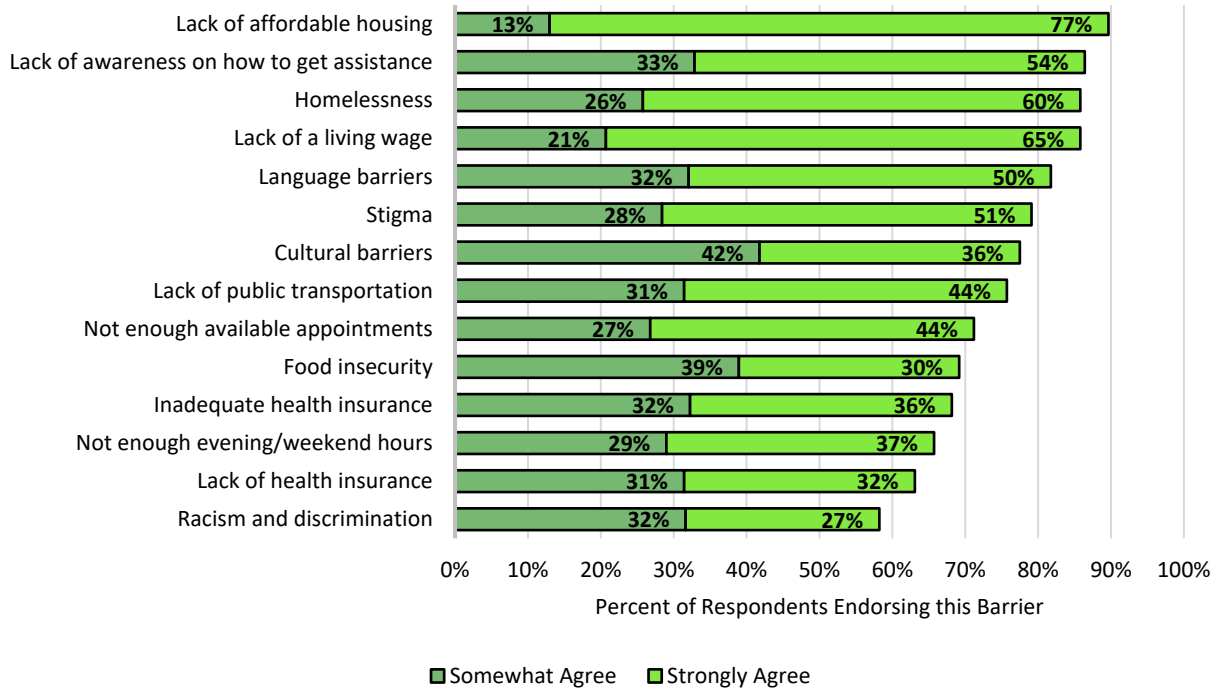
** MH: Mental health*

Note: Percentages reflect the proportion of survey respondents who selected "Limited or no access" when asked, "Thinking about the challenges in your region, please indicate the level of access and quality for each service type." Red highlighting indicates the highest percentage across all regions.

5.3. Barriers to Support and Services

Survey respondents were asked to indicate to what extent they agreed that a range of factors were barriers to individuals' ability to access needed support and services (Figure 10 and Table 11). These responses were combined with other primary data to illuminate key barriers for Rhode Island residents.

Figure 10. Deep-Rooted Barriers to Required Support and Services



Almost all respondents reported that homelessness and lack of affordable housing were formidable barriers for the five target CCBHC populations. This was the case across all CCBHC regions, though levels of concern about homelessness were slightly lower in Newport and Washington than in other areas. As stated above, many individuals experiencing homelessness fall into one or more of the CCBHC population groups. For example, a review of data from multiple high-income countries estimated that over three-quarters of individuals experiencing homelessness had a current mental illness, with over a third having AUDs, over a fifth having drug use disorders, over a tenth having schizophrenia spectrum disorders, and a similar proportion having major depression.[18] In the US, about 21% of people experiencing homelessness on a single night in 2020 were estimated to have SMI and 17% were estimated to have SUD.[19] Respondents' experience-based assessments echoed these data, and most engaged and non-engaged individuals shared their experience living without a home. As one person recounted, "I have been homeless for eight years this time. I started Suboxone and getting help from (aspiring CCBHC) caseworker with housing and program applications. I see a doctor next week at (FQHC) and hope I can get back on my depression medication."

Language was identified as another troubling barrier in all regions, though rates of concern were highest in Pawtucket, Providence, and Bristol/East Bay and lowest in Washington. Cultural barriers were noted in all regions as well; these followed a similar pattern, with rates of concern being highest in Providence and Pawtucket and lowest in Washington. Respondents shared that cultural differences can be a barrier that prevents individuals from engaging with the health system. For example, a provider shared that they provide cultural competence training and believe this has increased staff understanding of diverse perspectives, with a possible impact on client engagement. Individuals who speak English and are currently engaged in treatment recognized the effort of staff that they worked with: as one individual put it, "They are trying to help… I believe that." Findings regarding language and cultural diversity are

also congruent with the information that emerged from secondary and existing data. In both the Pawtucket and Providence regions—among the most likely to endorse these barriers—the non-Hispanic White population is a minority group (34% in Providence and 41% in the Pawtucket region); in contrast, these regions' proportions of Hispanic or Latino (43% and 36%) and non-Hispanic Black (13%) residents are larger than in the state as a whole. For Providence, the proportion of non-Hispanic Asian residents is also larger (6% vs 3%). Additionally, more Providence and Pawtucket residents are foreign born (31% and 28% vs 14% in Rhode Island) and more speak a language other than English at home (49% and 46% vs 22%). Among those speaking a language other than English, Spanish is the most common language in both Providence (76%) and Pawtucket (63%), and more Providence Spanish speakers speak English less than "very well" compared to the state (47% vs 42%).

Stigma was also recognized as both an interpersonal and structural barrier. Respondents endorsed it as a barrier relatively frequently across regions, though rates were highest in Providence and Pawtucket and lowest in Washington and Newport. Many individuals' stories echoed this; for example, one person shared, "Emergency room treats me like ****. I was really sick—OD (overdose)—was there for maybe six hours and then I was back on the streets." Another individual reported that he could not speak English so "no one will help." This is consistent with existing evidence that marginalized groups often face systemic barriers such as stigma, discrimination, and cultural insensitivity in primary care and mental health care settings, which can deter them from seeking treatment.[78,79] Limited access to affordable and culturally competent mental health services makes engagement even more difficult for these groups.[78,80]

Lack of a living wage consistently arose as a challenge across the domains examined in the survey (i.e., groups especially needing help, access concern areas, and barriers to needed services), and respondent and individual findings were consistent across these areas. Across all CCBHC regions, similar proportions of survey respondents agreed that lack of a living wage is a barrier. Transportation was also mentioned as a challenge many times by individuals and providers, and was endorsed frequently by survey respondents in all regions, with the highest rate in Washington and the lowest rates in Northern RI and Newport. One individual remarked, "I cannot get to my appointments on time—buses are always late." In Providence, respondents and providers all regarded the transportation system as a trouble spot: "If you have to be there at a specific time—leave at least an hour before. This is not possible for individuals trying to get to appointments and work." Additionally, a lack of sufficient available appointments and evening and weekend hours were rated as top barriers by both individuals and respondents, though they were higher concerns for individuals. On the survey, concerns about appointment availability were highest in Providence and lowest in Northern RI and Newport, while concerns about evening and weekend hours were highest in Providence and lowest in Washington, Northern RI, and Newport.

Table 11. Deep-Rooted Barriers to Required Support and Services, by CCBHC Region

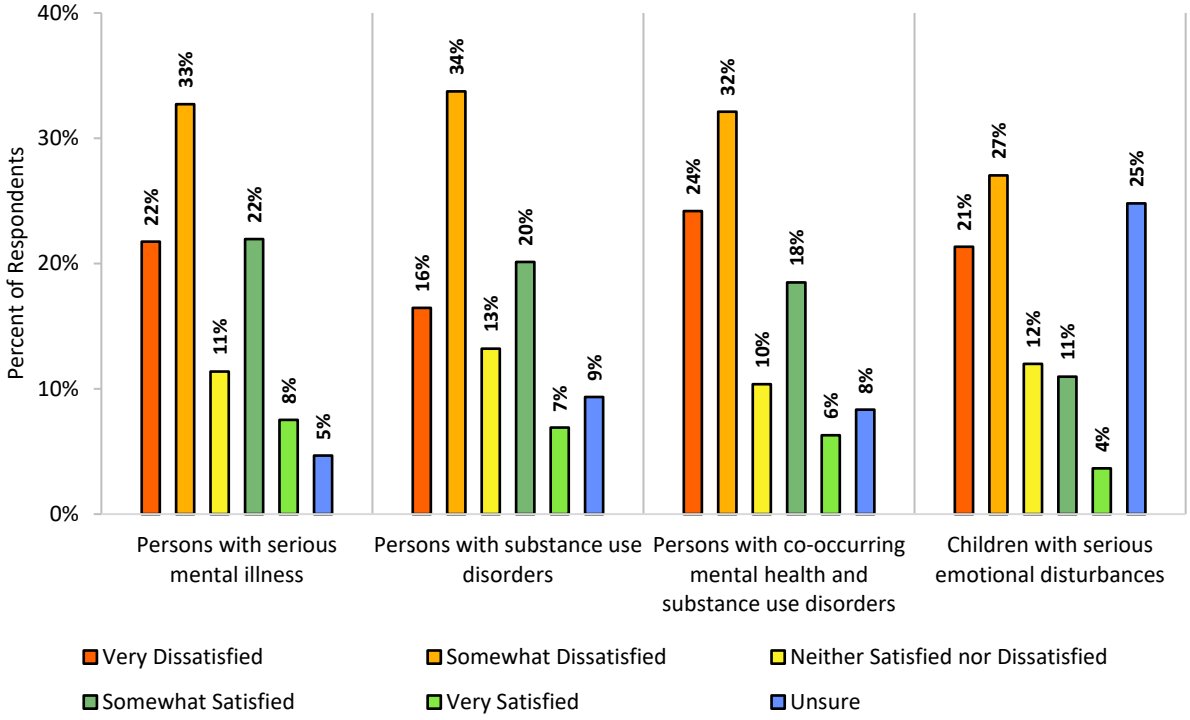
	Providence Region (n=207)	Pawtucket Region (n=117)	Northern RI (n=146)	Johnston/ West (n=106)	Bristol/ East Bay (n=109)	Kent Region (n=121)	Washington Region (n=107)	Newport Region (n=126)
Lack of affordable housing	92.8%	93.2%	88.4%	91.5%	94.5%	90.9%	92.5%	88.1%
Lack of assistance awareness	88.9%	87.2%	85.6%	87.7%	90.8%	91.7%	90.7%	83.3%
Homelessness	90.3%	89.7%	86.3%	84.9%	88.1%	85.1%	84.1%	83.3%
Lack of a living wage	87.9%	85.5%	87.0%	86.8%	87.2%	89.3%	86.0%	85.7%
Language barriers	90.8%	91.5%	85.6%	84.9%	89.9%	85.1%	77.6%	84.1%
Stigma	86.5%	85.5%	80.1%	78.3%	78.0%	81.0%	73.8%	75.4%
Cultural barriers	86.0%	84.6%	80.8%	78.3%	79.8%	81.0%	72.0%	79.4%
Lack of public transportation	81.2%	78.6%	74.7%	76.4%	80.7%	80.2%	84.1%	74.6%
Limited appointment availability	82.1%	77.8%	71.9%	74.5%	76.1%	79.3%	73.8%	72.2%
Food insecurity	71.5%	75.2%	74.0%	65.1%	68.8%	67.8%	67.3%	63.5%
Inadequate health insurance	68.1%	65.0%	61.6%	59.4%	63.3%	63.6%	57.9%	62.7%
Limited evening/ weekend hours	75.4%	72.6%	67.8%	71.7%	71.6%	69.4%	67.3%	68.3%
Lack of health insurance	69.6%	63.2%	61.0%	63.2%	65.1%	59.5%	60.7%	57.1%
Racism and discrimination	70.5%	70.1%	63.7%	62.3%	62.4%	66.9%	57.9%	58.7%
Criminalization/ aggressive policing	64.3%	69.2%	58.2%	57.5%	56.0%	62.0%	50.5%	54.0%
Inadequate quality of care	56.5%	51.3%	41.1%	48.1%	46.8%	50.4%	45.8%	46.8%
Neighborhood violence	53.1%	54.7%	45.9%	42.5%	42.2%	43.0%	37.4%	35.7%
Confidentiality concerns	31.4%	35.9%	26.7%	30.2%	30.3%	31.4%	30.8%	29.4%

Note: Percentages reflect the proportion of survey respondents who selected "Somewhat agree" or "Strongly agree" when asked, "To what extent do you agree that the following barriers prevent people in your region from getting services that they need?" Red highlighting indicates the highest percentage across all regions.

5.4. Satisfaction with Services

Survey respondents were asked to indicate their level of satisfaction with the range of services available for specific groups (Figure 11 and Table 12). Again, these responses were combined with other primary data and are discussed below.

Figure 11. Satisfaction with Range of Services for Selected Groups



For each group examined, 30% or fewer of survey respondents were satisfied with the range of services available. This held true across all CCBHC regions, though specific rates varied. Regarding services for individuals with SMI and for children with SED, dissatisfaction was highest among survey respondents in Washington and lowest among those in Northern RI; regarding individuals with SUDs, dissatisfaction was highest in Providence and Pawtucket and lowest in Johnston/West and Northern RI. Dissatisfaction regarding services for individuals with co-occurring disorders was relatively comparable across most regions, but somewhat lower in Northern RI.

While this data on service satisfaction is unfavorable, individuals who were currently receiving support and services from aspiring CCBHCs generally felt positive about the staff and level of support they were receiving. There were some concerns expressed about being on waiting lists, wanting a peer specialist, and having to be assigned a new provider because their previous provider left. Individuals also appreciated the services they were receiving from potential DCOs and some specific service providers in their regions. Digging further with survey respondents who gave "very dissatisfied" and "somewhat dissatisfied" ratings, it appears that some dissatisfaction stems from bad experiences their clients had or were having with providers not being available or not responding to urgent calls. One individual not currently engaged in support or services stated, "They were so rude to me; I called many times about my medication making me sick and no one called me back."

Transitions were another factor in the dissatisfaction ratings. Respondents noted the persistent occurrence of individuals being released from jail or discharged from the ED or hospital without a plan. Aspiring CCBHCs and respondents reported that they are not informed of these releases or discharges, so a plan is not devised and there is no care coordination. In addition, respondents and individuals

expressed dissatisfaction with providers not understanding that addiction is a disease and lacking compassion for their current circumstances.

Language was another area of dissatisfaction. One respondent noted, "Many cannot communicate with my clients because they do not speak the language." Translation services can help in some instances; however, providers shared that to build a personal connection, service providers must speak the person's language. All groups pointed out the difficulty of finding and hiring Spanish-speaking staff, as well as staff proficient in several other languages.

As stated previously, respondents reported that they do not know what services are available or how to assist their clients with gaining access. They shared that while they have lists of potential resources, often what is listed is no longer available or the eligibility criteria is not well defined. For example, one survey respondent shared, "When I call, I find out that the person I am working with does not qualify and I continue to search. When I finally find a program—there is a waiting list." In addition, fatigue and frustration grows as direct care staff cannot get clients what they need: "I am never going to get this guy housing, but I talked to him several times a week about getting housing." Aspiring CCBHCs, respondents, and providers reported a phenomenon referred to as "case management fatigue," in which individuals in the field are constantly facing waiting lists and being unable to connect the people they are working with to needed support and services due to a range of dead ends (e.g., no supportive housing or low-barrier options).

Table 12. Satisfaction with Range of Services for Selected Groups, by CCBHC Region

	Providence Region (n=206)	Pawtucket Region (n=117)	Northern RI (n=146)	Johnston/ West (n=106)	Bristol/ East Bay (n=109)	Kent Region (n=121)	Washington Region (n=107)	Newport Region (n=116)
Persons with Serious Mental Illness								
Satisfied	17.5%	18.8%	28.8%	19.8%	25.7%	19.0%	26.2%	26.2%
Dissatisfied	62.1%	61.5%	50.7%	62.3%	56.9%	59.5%	68.2%	55.6%
Persons with SUDs								
Satisfied	19.4%	16.2%	22.6%	18.9%	19.3%	16.5%	30.8%	23.0%
Dissatisfied	56.8%	56.4%	48.6%	48.1%	54.1%	52.9%	55.1%	50.8%
Persons with Co-occurring Mental Health and SUDs								
Satisfied	16.0%	12.0%	22.6%	15.1%	16.5%	12.4%	22.4%	19.8%
Dissatisfied	62.1%	63.2%	53.4%	58.5%	60.6%	62.0%	62.6%	57.9%
Children with Serious Emotional Disturbances								
Satisfied	11.7%	11.1%	20.5%	10.4%	8.3%	13.2%	20.6%	11.9%
Dissatisfied	48.5%	50.4%	46.6%	50.0%	51.4%	49.6%	60.7%	52.4%

Note: Percentages reflect the proportion of survey respondents who responded "Very Dissatisfied"/"Somewhat Dissatisfied" or "Very Satisfied"/"Somewhat Satisfied" when asked, "How satisfied are you with the range of services for each of the following groups?" Red highlighting indicates the highest percentage across all regions.

6. Considerations

This CNA's data collection, analysis, and validation process revealed many, though certainly not all, gaps and fault lines affecting Rhode Island's behavioral health system. Gaps represent key areas that are missing and that increase access and/or quality concerns. Fault lines are viewed as "breaks" in the functional safety net entrusted with providing vital support and services for the state's most vulnerable and marginalized individuals. Throughout these gaps and fault lines, inequities are ingrained. Inequity, a

formidable factor impeding any transformation effort, is defined as deep-rooted interpersonal and structural barriers that result from pervasive racism, discrimination, and injustice. Health care, including behavioral health care, acts as a structural barrier that functions as another enforcer of inequity.

This CNA focused on the five CCBHC population groups, discussed in Section 1.1. These populations expand the traditional CMHC model. CCBHCs function as Medicaid safety net providers in that they are building an integrated, accessible, quality network of community care for the state's poor and underserved populations. This section of the statewide CNA presents considerations based on the overall data synthesis, including assessments shared by direct care providers and individuals representing the five CCBHC target populations (including both those who are currently receiving support and services and those who are not).

6.1. Regional Differences

The CNA's purpose is to dig deeply into the unique needs of each CCBHC region. Secondary and primary data revealed vast differences within and between regions. This is best illustrated by the ADI, which combines 17 socioeconomic measures to create an index of neighborhood deprivation, in which a score of 1 represents the lowest deprivation level and 10 represents the highest. This measure reflects key elements of the Equity Conceptual Model (Figure 2) necessary to identify populations facing structural barriers. Well-established national findings and this CNA reveal that the current model of care leaves a substantial portion of the CCBHC target populations unengaged and in need of support and services, especially in high-deprivation areas. Neighborhoods ranking 10 are concentrated in specific regions (see Table 6). The highest number of neighborhoods with an ADI score of 10 are in the Providence region, with 29 neighborhoods that are home to 31,756 people. Providence is followed by the Pawtucket region, which has 21 neighborhoods ranking 10, with a cumulative population of 30,560. The third region, with approximately half of the population (15,972 vs 31,756) and neighborhoods (14 vs 29) ranking 10 as Providence, is the Northern RI region. These areas of high-density deprivation require different CCBHC models than other parts of the state. As the vision for the future of CCBHCs is reimagined, states and providers are asked to examine every aspect of service delivery for children, adults, and communities, including addressing inequity, with the core mission of reaching those not currently engaged and retaining engaged individuals who continue to need support and services.[4]

> Highly effective CCBHCs intentionally center their work in health equity, [providing] outreach necessary to better understand where individuals and groups within their communities experience gaps in access, inferior care quality, worse health outcomes, a lack of knowledge about available services or a sense of disconnection or exclusion from services.
>
> *– Source: CCBHC Vision for the Future*[4]

Rhode Island has begun the behavioral health transformation process with its efforts to develop the CCBHC model throughout the state. Leaders are using a consensus decision framework to create a solid foundation for this work, involving many forms of community, provider, and government participation. Such a consensus-building approach supports transformation, demonstrates a commitment to addressing inequity, and will help to envision and grow a CCBHC model that recognizes dramatic regional differences, addresses each region's needs, and improves outreach to CCBHC populations not currently engaged. The State also made available CCBHC and DCO infrastructure grants, which provided substantial funding for CCBHC transition efforts to organizations in each CCBHC region. In addition, Health Equity Zones (HEZs) are now established throughout Rhode Island. Many of these HEZs match the

neighborhoods with the highest ADI ratings, and representatives of these partnerships provided critical insight during primary data collection for this CNA. Evolving CCBHCs are working with HEZs, and these efforts may assist in addressing the elevated deprivation levels in specific neighborhoods

Rhode Island also leads the nation in developing and establishing needed support and services for Medicaid beneficiaries, and specifically those requiring behavioral health services. Some of these efforts and achievements are discussed throughout this section and demonstrate the necessary expertise and commitment to transforming the behavioral health continuum.

6.2. Fault Lines

This CNA identified several fault lines, defined as "breaks" in the functional safety net that provides vital support and services for the state's most vulnerable and marginalized individuals. Several interview participants and providers identified capacity as a key factor in low outreach, access, and quality satisfaction ratings, citing issues such as not being able to get an appointment, getting inaccurate information, not returning phone calls even in an emergency, being treated badly, and experiencing stigma or racism/discrimination. Providers pointed out that they believed that the workforce crisis impacts every aspect of support and care, which then decreases capacity and increases access and quality concerns.

6.2.1. Workforce Vacancies

An overall pervasive workforce deficit is a fault line impacting CCBHCs and the full continuum of support and services. The workforce shortage and high turnover rates create access and quality concerns, such as long wait times and program closures. The current provider workforce shortages and the turnover rates experienced by some providers, all of whom will have a vital role in CCBHC development, continue to be disruptive and will require additional remedies. Providers believe that salary increases are one such remedy, and that low salaries are the underlying reason for the lack of applicants and continual vacancies. Nevertheless, there is a gravitational pull for licensed providers to leave functional safety net provider organizations and seek employment in the private sector.

> Workforce Innovation: Highly effective CCBHCs use the model as an opportunity to re-envision individual staff and team roles. [This can include] strategic decisions in the face of workforce shortages to scale back educational and vocational requirements for certain roles, such as positions previously filled by master's level staff.
>
> *– Source: CCBHC Vision for the Future*[4]

Salary can have an important impact on both licensed and unlicensed workforce challenges. Unlicensed staff, particularly those on the front lines, must earn a living wage. With the lack of affordable housing in most regions and the costs of food, gas, and other daily expenses, committing to a functional safety net position, initially or for the long term, may not be a viable choice even when individuals love their jobs and are personally aligned with the mission of their work. Many CNA respondents who work directly with the CCBHC populations reported being on the edge of homelessness despite working two jobs. For example, a respondent providing care coordination shared that because she could not afford her rent, she had to move into a friend's apartment, where she shared a bedroom with her two school-aged children. This salary deficit was consistently a great concern for respondents, especially since frontline staff have an essential role in reaching individuals currently not engaged in CCBHC support and services and retaining engaged individuals with ongoing support needs. As one interview participant explained, "If it wasn't for my case worker, I don't believe I would have stayed off the street." Another noted, "He

(direct care provider) gets me—he has been where I am. The psychiatrist and counselor are OK, but they don't know what I am about."

Notably, the state has provided funding to aspiring CCBHCs and DCOs that would allow providers to increase salaries. As the state rolls out the CCBHC model, certified CCBHCs and their DCOs will receive a higher rate of reimbursement through the selected Medicaid prospective payment model. Revisiting salary and turnover strategies to determine their role in addressing workforce shortages could help inform future interventions.

Turnover and Burnout: Preventing and decreasing turnover was a notable workforce concern among respondents. On the state and national levels, many organizations see the benefits of strategies that decrease staff turnover. These strategies, if effective, could also decrease the cost and time of training new staff. Because seasoned and committed staff have a key role in service quality, these changes could also improve quality and client outcomes. Examples of retention strategies include:[105]

Symptoms of Burnout:

- Exhaustion—feeling depleted, overextended, and fatigued
- Depersonalization—being detached from oneself and emotionally distant from one's clients and work
- Feelings of inefficacy—having a reduced sense of professional accomplishment

Source: SAMHSA Guide to Addressing Burnout[105]

1. Evaluating employee satisfaction: Conducting a confidential survey (not carried out by the organization); practicing transparency by sharing results; devising an action plan based on input; and monitoring changes in workplace climate.
2. Assessing workload: Monitoring and evaluating workload; considering options to balance division of labor; and conducting team huddles to provide support for high-needs clients.
3. Offering other benefits: Paying for licensure, continuing education units (CEUs), continuing medical education (CME) credits, and/or other professional costs; offering loan forgiveness and/or scholarships; and considering additional benefits based on employee satisfaction surveys.
4. Considering workplace environment: Offering flexibility (such as in work hours and/or working remotely when appropriate); utilizing a reflective model of support and supervision; decreasing administrative burden; and offering staff a say in decision-making.

In addition, several participants discussed burnout due to chronic workplace stress, including "case management fatigue" from continual challenges connecting individuals to needed services. To strengthen and retain the workforce, burnout must be recognized and addressed. Participants reported that they felt drained and exhausted after work and that their work did not matter (e.g., "There is nothing I can do that will help my client"). Many comments displayed the signs of burnout. Several providers shared that they are working to support staff by decreasing stress and acknowledging how hard the work is, along with "being grateful for the small steps." Recognizing burnout as a debilitating factor, SAMHSA created an evidence-based resource guide that some providers find helpful.[105]

> Peers not only directly expand access to care, their services in a variety of settings (e.g., supporting crisis care, assisting in care coordination services, supporting individuals during and after emergency room visits and hospital stays and helping individuals transition from justice settings) may also allow for different staffing compositions that support other staff to optimize their licensure.
>
> *– Source: CCBHC Vision for the Future*[4]

Reimagining the Workforce: The long-term vision of the CCBHC model entails efforts to reimagine the workforce.[4] One such effort is supporting staff to work at the top of their licensures by adding positions or redefining workflows, which in turn allows clinicians with advanced training to use these skills to their fullest capacity. This is a strategy used by several aspiring CCBHCs. Additionally, the future vision of the CCBHC model expands and integrates the role of staff with lived experience. Many seasoned CCBHCs are reimagining their workforces along these lines. In a recent presentation, Josh Cantwell, Chief Operating Officer of GRAND Mental Health in Oklahoma, reported that his organization had redefined what a therapist was. They no longer hire therapists; instead, they hire "integrated team managers." These teams consist of the team manager, a peer, and a care coordinator and provide support and services that improve the overall health outcomes of twice the number of clients as the organization's original design. The team managers take on management tasks and are paid more. Reportedly, this has drastically improved the organization's ability to recruit and retain staff.

Peer specialists and other providers with lived experience were viewed positively by interview participants and survey respondents. There was a consistent recognition that individuals with lived experiences have a vital role. Having peer specialists as a central part of all teams is a CCBHC goal and can increase access and engagement. Many high-performing CCBHCs have peer specialists supporting individuals in crisis care, during and after ED visits and hospital stays, and during transitions out of the criminal legal system. The peer model is not limited to SUDs and mental health; instead, CCBHCs are using trained and supported peers to engage and support veterans, unhoused individuals, youth, LGBTQ individuals, and marginalized racial and ethnic groups. Several Rhode Island aspiring CCBHCs have in-house peer training programs, and some are considering allowing community organizations to access this opportunity as well. This has the potential to infuse the workforce with individuals with lived and living experience. Also noteworthy is the fact that CCBHCs are expanding their workforces to include community health workers (CHWs) in key team roles such as outreach, care coordination and navigation, social and economic needs assessment, engagement, and re-engagement. CHWs have gained high respect in reaching individuals not currently engaged and have a key role in the continual engagement of vulnerable and marginalized individuals.

In addition, Rhode Island has been working to address workforce challenges via a range of other strategies. On an individual organization level, many groups have created health care education and training programs, including a number that are based in and lead into positions within individual organizations. On a State level, an ongoing workforce planning effort has brought together representatives from across the health system, as well as advocates, policymakers, and education and training groups, to strategize ways to address workforce shortages, lack of diversity, and training needs. The group's areas of focus include developing pipelines, reviewing data and improving data collection to better understand workforce dynamics, and identifying regulatory changes (such as loosened degree requirements) that could make it easier for individuals to enter the health care field. In addition, the initiative provides a venue for its 160 partner organizations to share lessons learned, discuss challenges

they encounter, and connect with State officials and others who can collaborate to address those challenges. Outside of this initiative, other State efforts to address workforce issues include expanding the use of CHWs by updating payment options, broadening their role, and creating advancement opportunities. Rhode Island has also invested American Rescue Plan Act (ARPA) and CCBHC funding in recruitment and retention among home- and community-based services (HCBS) agencies, and has recently released a review study recommending increased Medicaid reimbursement rates in a number of settings, including behavioral health.

6.2.2. Reaching Individuals not Currently Engaged

Inequity was a central element of the contextual framework for this CNA. Behavioral health care support and services replicate and enforce systemic barriers. These systemic barriers are caused by discrimination, racism, and stigma, and manifest themselves in poverty, incarceration, homelessness, poor access, and low-quality behavioral health care. Among survey respondents, between 71% (Providence) and 60% (Washington) viewed racism and discrimination as a blatant barrier to both access and quality. Although addressing inequity is a deliberate function within the CCBHC model, this function is evolving. Specific racial, ethnic, and age groups were identified in this CNA as having substantial needs for support and services (Section 5.1). These groups, based on all sources of data, include Black individuals of any ethnicity, Hispanic and Latino individuals, and children and transition-age youth. These populations are disproportionately facing poverty, homelessness, criminal legal system involvement, debilitating mental health conditions, and/or addictions. In addition, other groups that emerged as having substantial needs included domestic violence survivors, individuals who are un- or under-insured, individuals with I/DD, and LGBTQ individuals.

Unhoused Individuals: Homelessness is a forbidding inequity disproportionally impacting Black and Hispanic/Latino individuals. Respondents in every region ranked individuals who are battling chronic homelessness (homeless for more than 1 year) as having particularly high needs. Respondents shared their dismay and frustration with "non-existent" housing options and reported the need for low-barrier, transitional, supportive, and low-income housing. Many respondents working directly with unhoused individuals shared that they work with them to get all the "paperwork" completed: "We need designated people just to complete the applications and supporting documents." Many also shared their frustration about their inability to connect individuals with the housing they need: "There are so many that need low-barrier transitional and supportive housing options." Some respondents reported working with individuals to inform and engage them in harm reduction and initiation of MAT while homeless. Several individuals who have been chronically homeless for years and continue to be without a home shared that they had reengaged in support and services, including job training. Some providers recounted similar stories: "No luck with getting this guy a place to live but he is sober, involved with job training—I can see him getting a job soon."

> Promoting Access: Ensure help is available when and where people need it by offering streamlined, same-day access to treatment and access points across diverse community settings.
>
> *– Source: CCBHC Vision for the Future*[4]

There is a housing crisis nationally and within Rhode Island, with individuals and families losing their homes because they cannot afford the rent. Participants reported that low-income housing options are limited. They also reported that in many instances, tenants are not getting representation during the eviction process: "The process supports the property owner and many tenants do not understand that they have rights, especially those who do not speak English." Once someone is evicted, they may have a

difficult time finding another apartment due to limited supply and the stigma that comes from an eviction. For example, one interview participant who reported living with SMI and SUD shared that she lost her apartment after an eviction process. She did not know what to do or where to get help. Her two children are living with her aunt in her one-bedroom apartment. Since there is no room for her, she has been homeless, not taking her medications, and reports incidents of abuse and sexual assault. Before the eviction, she reported not being homeless.

Across all of its initiatives, the Rhode Island Executive Office of Health and Human Services (EOHHS) is encouraging providers to focus on individuals experiencing homelessness, those who actively use drugs, and those who are or have been incarcerated. EOHHS is also working with the Rhode Island Office of Housing and Community Development (OHCD) to support the development of new housing units that meet the needs of vulnerable populations and to provide operating subsidies for those units. EOHHS and OHCD are also collaborating to create project development and funding recommendations that will help ensure that new efforts align with existing housing needs. This includes considering supportive housing models where multidisciplinary teams provide home-based services that address individuals' functional needs (e.g., paying utility bills, keeping the rental in good condition, etc.).

Individuals Experiencing Stigma, Language, and/or Cultural Barriers: All regions identified considerable barriers, access, and quality concerns directly connected to language and stigma. Concern about stigma was highest in Providence (85%) and lowest in Newport (75%). Interview participants representing the five CCBHC target populations reported consistent incidents of stigma. Individuals not engaged in support and services shared that their interactions with providers were a factor in their disengagement. "She (PCP) did not believe me. Blamed everything on my diagnosis (SMI)." Individuals battling addiction shared that providers and community members did not understand that addiction was a disease. A participant who has been in recovery on and off for 15 years shared, "People don't get it. I fight every day to stay sober." Another participant shared, "Don't want to talk to anyone. They treat me like ****. I know I am no good… have done a lot of bad things." Respondents and interview participants reported stigma as prevalent in the community and in the health and human services system.

Other experiences shared were specifically related to language and cultural sensitivity, with incidents of disrespect and being blocked from obtaining help. Language and cultural barriers were identified by respondents and interview participants as barriers to both access and quality. These were top concerns in the Pawtucket and Providence regions, where non-Hispanic White individuals are a minority group and Hispanic or Latino individuals make up a substantial portion of the population (43% and 36%). Additionally, more Providence and Pawtucket residents are foreign born (31% and 28% vs 14% in Rhode Island) and more speak a language other than English at home (49% and 46% vs 22% in Rhode Island), with over 40% of these individuals unable to speak English "very well." Respondents reported that culturally diverse and non-English-speaking populations have difficulty with access and engagement. Providers shared that they are providing training to staff to increase cultural competency, but continually have difficulty hiring diverse staff who speak the languages represented in their community. One provider reported using a Spanish-speaking peer specialist to engage and retain Spanish speakers; however, overall, providers reported that finding staff who spoke Spanish is a challenge and adds to the waiting period to access support and services. Interview participants shared these concerns as well. Some culturally diverse participants did not trust those from different cultures, although one respondent shared that after a while he was trusting more.

Connecting those who do not speak English and those from diverse cultures with peer specialists and/or CHWs who speak their language and represent their culture is an evidence-based practice and has been identified as a central goal for CCBHCs as they continue to evolve.[4] Several aspiring CCBHCs and DCOs have in-house peer specialist training programs, with some pulling from their community's diverse backgrounds. In addition, the State has given grant funds to several community organizations representing the diverse languages and cultures in each region. These grantees are working diligently to become DCOs and provide a pipeline of individuals who could become engagement agents, creating access for individuals with diverse backgrounds and languages.

Children and Transitional-Age Youth: Reaching children through schools was consistently assessed as a gap in high-needs regions. School systems in these areas reported that they do not have the resources to support the presence of a mental health and substance misuse professional. Although some had social workers or counselors, most of these individuals were covering several schools. Many survey respondents reported that school-based mental health and substance use initiatives were needed. School systems that assessed suicidality and drug use among middle and high school students revealed alarming rates of both. The statewide data revealed that 17% of high schoolers and 23% of middle schoolers had seriously considered suicide in the past year[87] and that 11% of Rhode Islanders aged 12-17 had used illicit drugs in the past month.[82] While some regions do have embedded, school-based health and mental health clinics, the regions with the highest needs have less access to these critical gateways. This is another indication of the inequity that exists between regions. Interview participants who had children in school-based clinics reported that they appreciated and valued them. They believed that their children were "doing better" because of these resources. Notably, several interview participants reported that they had tried to get an appointment at an aspiring CCBHC and could not; however, when they learned about the school-based clinic, they were able to get an appointment.

In addition, several respondents reported that there were limited options for children under five and minimal support for guardians. Developing the capacity to support young children and their loved ones is a priority for many CNA participants.

> [CCBHCs must increase their effort to reach individuals not engaged in care and services by] embedding staff and services in high-need settings cross the community—such as jails, prisons, homeless camps, emergency departments, schools, and juvenile systems.
>
> *– Source: CCBHC Vision for the Future[4]*

Notably, Rhode Island achieved a stunning accomplishment when it established a statewide pediatric Mobile Response and Stabilization Services (MRSS) system that responds to behavioral health crises. The program, which has now been running for over one year, has served over 500 people. For the 495 for whom disposition data is currently available, 92% were able to get care in the community without involvement of the ED or law enforcement. During the time period that this program has been in place, Rhode Island moved from consistently having 35 to 40 youth boarding in the ED on any given day to having zero or only a few. The State has also been working with inpatient facilities to shorten lengths of stay for youth who do require psychiatric hospitalization.

In addition to MRSS, Rhode Island has ongoing school-based efforts to improve youth behavioral health. The Rhode Island Department of Education (RIDE) partners with Ginn Group Consulting to support SMART Centers in selected schools, including three in Providence and two in Central Falls. This model provides both physical and mental health care and is able to bill insurance for services provided. The

State also provides some funding to FQHCs to support additional school-based health clinics in other locations. Currently, schools are able to bill Rhode Island Medicaid for services provided to students who are Medicaid-eligible and have individualized education programs (IEPs); the State is pursuing a waiver to expand this so that Medicaid can be billed for eligible students regardless of IEP status. In addition, Project AWARE, a SAMHSA-funded effort to support the development of sustainable school-based mental health infrastructure, has been implemented in 10 Rhode Island school districts to date. The State has also taken advantage of a number of other grant opportunities to support behavioral health in schools, including funding to transform school climates, promote trauma-informed services, and recruit and retain staff, and continues to monitor new grant opportunities and look for ways to synergize work across these various efforts. In addition, Rhode Island has convened a Trauma-Informed Schools Commission to review existing resources and develop recommendations. Schools are also able to refer to the Rhode Island Department of Children, Youth, and Families (DCYF)'s home-based services, which are available to all families and aim to prevent the need for formal DCYF involvement, hospitalization, or out-of-home care. DCYF also supports five Family Care Community Partnerships (FCCPs), which are community-embedded organizations providing family-centered, strengths-based, wraparound services.

Individuals Involved with the Criminal Legal System: Individuals leaving prison face daunting barriers in accessing basic needs and behavioral health services. RIDOC reports providing coordinated discharge services for incarcerated individuals diagnosed as having a serious and persistent mental illness (SPMI), including ensuring that they have Medicaid coverage, managed care enrollment if necessary, and a referral with an appointment at a CMHC. In addition, a separate contractor provides MAT for individuals during incarceration and MAT discharge planning. However, specific gaps exist for incarcerated individuals whose release date is unpredictable, as well as for those who are on psychiatric medications who may not be known by the RIDOC discharge team. This means that individuals from either group could potentially be released without the necessary links, even though a vast number of incarcerated individuals fall into one or more of the CCBHC target populations. It is also important to note that since individuals from marginalized racial and ethnic groups are incarcerated at disproportionate rates (see Section 3.3), it is likely that these groups are also disproportionately represented among those experiencing these challenges. Individuals leaving RIDOC require outreach and engagement in support and services. Embedding staff and services for individuals leaving jails and prisons is a key goal for evolving CCBHCs nationally; this includes having CHWs and/or peer recovery specialists as part of the team to provide needed support within the community. Training to connect individuals with benefits they may be eligible for, such as that available through SSI/SSDI Outreach, Access, and Recovery (SOAR), is also important for staff members working with behavioral health populations. Additionally, the State is discussing possible plans to use opioid settlement funding to support discharge processes and provide for basic needs for individuals being released.

Several aspiring CCBHCs and community programs have criminal legal system diversion initiatives such as embedding staff with first responders and supporting substance use and mental health courts. The efficacy of these initiatives to divert individuals and propose alternatives to incarceration can improve outcomes and decrease inequity. Other statewide efforts include partnering with a community health center to provide 24/7, low-barrier access to harm reduction tools through vending machines in selected RIDOC facilities, as well as in probation offices throughout Rhode Island. EOHHS is also encouraging a focus on key vulnerable populations, including those who are or have been incarcerated, in all of its programs.

6.3. Gaps

For this CNA, gaps represent key areas that are missing, and which thereby increase access or quality concerns. Many providers also link gaps with the workforce crisis and inadequate initiative funding, while also acknowledging that transitions and improvement of quality satisfaction require attention and innovation. Not knowing what services are available and whether individuals qualify for a specific service was a consistent gap identified by survey respondents and interview participants.

6.3.1. Transitions of Care

Many interview participants reported leaving the hospital or ED without a plan. They left the facilities not knowing where to get MAT or psychiatric medications, and did not receive a referral or appointment with an outpatient provider. Notably, EDs are focused on medically acute admissions and have been overwhelmed with boarding patients who do not require ED services; however, it is surprising that hospitals are sometimes discharging patients without a plan. It is unclear if this could be a workflow issue or due to a lack of staff who focus on transitions. As shared by an interview participant, "I was hospitalized after a suicide attempt. I was in the hospital for two weeks and got back on medication. Left the hospital with nowhere to go. I had nowhere to go to get medication and housing." Several other individuals shared similar experiences. Some found refuge in a homeless shelter, where a case manager worked with them to connect them with possible resources such as accessing MAT or psychiatric medications.

Nationally, many CCBHCs have found that embedding a peer specialist in the ED helps with connecting individuals to resources and also decreases the stigma associated with addiction and mental health conditions. As one peer specialist put it, "I developed relationships with the ED staff, and I would share my story. This, I believe, helped them see—especially addiction as a disease. They began calling on me more and seeking my input and involvement." In Rhode Island and nationally, bridge clinics have developed into an option to divert patients who do not present an acute emergency but do need support and services in accessing low-barrier and harm reduction options. These bridge clinics also provide on-the-spot MAT options and palliative care medications that can ease withdrawal symptoms. Bridge clinics can be established by a variety of providers, including hospital behavioral health teams, area FQHCs, or CCBHCs directly or through a DCO.

Rhode Island is a national leader in implementing peer recovery services, including through Anchor ED, which provides 24/7 on-call access to peer recovery specialists for individuals who present to EDs with substance use challenges. Peer organizations in the state also receive monthly heat maps showing regional ED and emergency medical services (EMS) overdose data, enabling targeted responses. Other approaches in use include offering low-barrier harm reduction services via drop-in centers around the state; supporting at least three centers focused on youth; funding programs led by organizations that serve youth and/or use culturally specific and community-embedded approaches; and establishing an overdose prevention center (expected to open in 2024) that will provide harm reduction services and clinical supports. In addition, Rhode Island's Governor's Overdose Prevention and Intervention Task Force unites a wide range of stakeholders, including people with lived and living experience and community members. The Task Force works on prevention, rescue, harm reduction, treatment, recovery, and other specific populations and initiatives. It is currently the largest public meeting in the state, with over 100 people regularly participating in meetings. Founded in 2015, the Task Force has

added additional workgroups over its lifetime and incorporated a focus on social determinants of health and racial equity across all pillars of its work.

6.3.2. Awareness of Services

Not knowing what services are available was seen as one of the highest barriers to support and services by survey respondents. Interview participants echoed these concerns. As one respondent explained, "I sometimes hear about options from clients. The information I have many times is not current or accurate." Another noted, "I get all the paperwork done and then I am told that my client is not eligible or does not meet the criteria for the program." Exploring further with respondents, some thought the reason was just bad communication, some thought it was the turnover rate among frontline staff, and some who had been at their job for more than a year shared that situations change quickly: "We need real-time information readily available." One provider shared that his outreach team checks in daily and includes updates on resource changes. Often, one staff member uncovers a change and can then share that with the team. Interview participants also shared that they did not know what options were available. Several individuals who were actively using substances noted that they did not know where to access harm reduction resources, a gap that requires further investigation. Some providers believe that improving access to online platforms that provide better-updated resources would be helpful, and many are developing communication strategies such as daily resource huddles to share updates. In addition, many of the statewide efforts described above involve coordinating across silos, and there is a hope that these efforts and the implementation of the CCBHC model will help to address these challenges.

6.3.3. Quality of Support and Services

Respondents had elevated levels of dissatisfaction with the quality of support and services statewide for the CCBHC target populations. Regarding services available for those with SMI, statewide dissatisfaction was 85%; for those with SUDs alone, it was 77%; and for those with co-occurring SMI and SUDs, it was 81%. For services available to children with SED and their families, the level of dissatisfaction was 63%. Despite this, many interview participants who were currently engaged with SUD, child and family, and/or SMI services reported being very satisfied with their providers. Some did report difficulties with accessing support and services, especially if they needed to change an appointment or reschedule a missed appointment, or if their provider left and they had to wait to be reassigned. Several who experienced clinician turnover also reported that their case manager kept them engaged during the waiting period. In addition, although transportation was a great concern in many areas, several participants expressed gratitude when their provider arranged transportation (e.g., Uber), removing a barrier to engagement.

> Re-thinking Clinical Approaches to Care: Embrace the CCBHC model of care as an opportunity to examine every aspect of service delivery for children, adults, and communities.
>
> *– Source: CCBHC Vision for the Future*[4]

Factors that influenced satisfaction ratings included the fault lines outlined previously, including workforce limitations that directly impact access and quality. The State and providers, especially aspiring CCBHCs and potential DCOs, continue to work toward re-envisioning their workforces. Several have in-house peer specialist training programs, which will provide needed team members who can enable clinicians to work at the top of their licenses. In addition, peer specialists and others with lived experience can become engagement agents, reaching individuals who need but are not currently receiving CCBHC support and services. For example, several CCBHCs have hired veterans who

provide outreach, engagement, and staff training, increasing access for this underserved population. The State is also addressing workforce limitations through a variety of strategies (discussed above), including developing health care education and training programs, convening a collaborative workforce planning effort, and expanding the use of CHWs.

Two populations that suffer long-term inequity and high rates of SMI and SUDs are those who are homeless and those who are involved with the criminal legal system. Aspiring CCBHCs have staff embedded in criminal legal system diversion programs, including supporting SUD and mental health courts that focus on alternatives to incarceration. Several aspiring CCBHCs are also collaborating closely with individuals and providers to assist unhoused individuals and families. However, given the ongoing housing crisis, available affordable, transitional, and supportive housing does not meet the needs of this vulnerable and marginalized population, and many direct care providers are experiencing case management fatigue and burnout. As discussed above, the State is working to address these issues through supporting the development and operation of housing units that meet the needs of vulnerable populations, working to expand services and supports for those being released from incarceration, and ensuring that those experiencing homelessness and/or incarceration are a focus of all EOHHS programs.

In addition, aspiring CCBHCs and potential DCOs are working together to address the outreach and engagement needs of children and families, those with diverse cultural and language backgrounds, and other vulnerable and high-needs populations. This includes reimagining the workforce by adding staff who represent these groups and function as engagement specialists, as well as embedding staff in schools. These strategies are underway or being considered in high-needs regions, and several other regions have established school clinics for which guardians and school staff express appreciation and gratitude. State-level initiatives specific to youth, described above, include supporting school-based clinics, pursuing Project AWARE and other grant-funded initiatives to promote behavioral health in schools, making DCYF home-based services available to all families, and funding community-embedded wraparound care through FCCPs.

> Use data to identify populations facing health disparities and undertake specific quality improvement projects to improve outcomes.
>
> *– Source: CCBHC Vision for the Future*[4]

Using a consensus planning and decision-making model, the State, communities, and aspiring CCBHCs and DCOs are undertaking a behavioral health transformation process that will ensure that the full potential of the CCBHC model is realized and that the needs outlined in the statewide and regional CNAs are addressed.

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Appendix A: Community Needs Assessment Requirements[viii]

Criteria 1.A: General Staffing Requirements

1.a.1 As part of the process leading to certification and recertification, and before certification or attestation, a community needs assessment (see Appendix A: Terms and Definitions for required components of the community needs assessment) and a staffing plan that is responsive to the community needs assessment are completed and documented. The needs assessment and staffing plan will be updated regularly, but no less frequently than every three years.

- Certifying states may specify additional community needs assessment requirements.

Appendix A. Terms and Definitions

Community Needs Assessment: A systematic approach to identifying community needs and determining program capacity to address the needs of the population being served. CCBHCs will conduct or collaborate with other community stakeholders to conduct a community needs assessment. The assessment should identify current conditions and desired services or outcomes in the community, based on data and input from key community stakeholders. Specific CCBHC criteria are tied to the community needs assessment including staffing, language and culture, services, locations, service hours and evidence- based practices. Therefore, the community needs assessment must be thorough and reflect the treatment and recovery needs of those who reside in the service area across the lifespan including children, youth, and families. If a separate community needs assessment has been completed in the past year, the CCBHC may decide to augment, or build upon the information to ensure that the required components of the community needs assessment are collected.

The community needs assessment is comprised of the following elements:

1. A description of the physical boundaries and size of the service area, including identification of sites where services are delivered by the CCBHC, including through DCOs.
2. Information about the prevalence of mental health and substance use conditions and related needs in the service area, such as rates of suicide and overdose.
3. Economic factors and social determinants of health affecting the population's access to health services, such as percentage of the population with incomes below the poverty level, access to transportation, nutrition, and stable housing.
4. Cultures and languages of the populations residing in the service area.
5. The identification of the underserved population(s) within the service area.
6. A description of how the staffing plan does and/or will address findings.
7. Plans to update the community needs assessment every 3 years.

[viii] Source: Substance Abuse and Mental Health Services Administration. (2023). *Certified Community Behavioral Health Clinic Certification Criteria*. https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf

8. Input with regard to:

    - cultural, linguistic, physical health, and behavioral health treatment needs;
    - evidence-based practices and behavioral health crisis services;
    - access and availability of CCBHC services including days, times, and locations, and telehealth options; and
    - potential barriers to care such as geographic barriers, transportation challenges, economic hardship, lack of culturally responsive services, and workforce shortages.

    Input should come from the following entities if they are in the CCBHC service area:

    - People with lived experience of mental and substance use conditions and individuals who have received/are receiving services from the clinic conducting the needs assessment;
    - Health centers (including FQHCs in the service area);
    - Local health departments (Note: these departments also develop community needs assessments that may be helpful);
    - Inpatient psychiatric facilities, inpatient acute care hospitals, and hospital outpatient clinics;
    - One or more Department of Veterans Affairs facilities;
    - Representatives from local K-12 school systems; and
    - Crisis response partners such as hospital emergency departments, emergency responders, crisis stabilization settings, crisis call centers and warmlines.

    CCBHCs must engage also with other community partners, especially those who also work with people receiving services from the CCBHC and populations that historically are not engaging with health services, such as:

    - Organizations operated by people with lived experience of mental health and substance use conditions;
    - Other mental health and SUD treatment providers in the community;
    - Residential programs;
    - Juvenile justice agencies and facilities;
    - Criminal justice agencies and facilities;
    - Indian Health Service or other tribal programs such as Indian Health Service youth regional treatment centers as applicable;
    - Child welfare agencies and state licensed and nationally accredited child placing agencies for therapeutic foster care service; and
    - Crisis response partners such as hospital emergency departments, crisis stabilization settings, crisis call centers and warmlines.
    - Specialty providers of medications for treatment of opioid and alcohol use disorders;
    - Peer-run and operated service providers;
    - Homeless shelters and housing agencies;
    - Employment services systems;
    - Services for older adults, such as Area Agencies on Aging;
    - Aging and Disability Resource Centers; and

- Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs).

Appendix B: Existing Reports and Secondary Data Sources Reviewed[ix]

Rhode Island Reports and Data Sources

- 2021 Youth Risk Behavior Survey High School and Middle School Summary Tables (Rhode Island Department of Health)
- 2022 Behavioral Health in Rhode Island: State Epidemiological Profile (BHDDH/RI State Epidemiological Outcomes Workgroup)
- 2022 Integrated Housing Report (Rhode Island Department of Housing)
- 2022 Labor Force Revisions (Rhode Island Department of Labor and Training Labor Market Information Division)
- 2022 Rhode Island Student Survey (BHDDH)
- 2022 Rhode Island Substance Abuse Prevention Treatment and Community Mental Health Services Block Grant Needs Assessment (BHDDH/URI)
- 2022 Rhode Island Young Adult Survey (BHDDH)
- 2023 Rhode Island KIDS COUNT Factbook (Rhode Island KIDS COUNT)
- Addressing the Needs of Deaf, Hard of Hearing, and Deaf-Blind Individuals in Healthcare, 2022 (Rhode Island Department of Health)
- Adverse Childhood Experiences and Long-Term Health among Adults in Rhode Island, 2021 (Jackson & Monteiro/Rhode Island Department of Health)
- Adverse Childhood Experiences in Rhode Island: A Closer Look 2020 (BHDDH/RI State Epidemiological Outcomes Workgroup)
- Adversity and Mental Health of Sexual & Gender Minorities in Rhode Island, May 2022 (BHDDH/RI State Epidemiological Outcomes Workgroup)
- Alcohol-Related Emergency Department Visits in Rhode Island, 2018-2021 Rhode Island Data Brief (Rhode Island Department of Health)
- Alcohol Use Among Adults in Rhode Island, 2016-2020 Rhode Island Data Brief (Rhode Island Department of Health)
- BHOLD Data for Systems Review, 2022-2023 (BHDDH)
- Breaking Down Barriers: Young Adult Interest and Use of Telehealth for Behavioral Health Services, 2022 (Rosenthal et al.)
- Child Hunger in Rhode Island Issue Brief, December 2020 (Rhode Island KIDS COUNT)
- Children's Mental Health in Rhode Island, October 2022 (Rhode Island KIDS COUNT)
- Child Neglect and Abuse in Rhode Island: Prevention and Support for Children and Families Issue Brief, March 2022 (Rhode Island KIDS COUNT)
- Community Based Services Contracted by RI DCYF, SFY21 (Rhode Island Department of Children, Youth, & Families)
- Coronavirus Pandemic: The Rhode Island Economy February 2020 - June 2023 (Rhode Island Department of Labor and Training)
- Culturally and Linguistically Appropriate Services (CLAS) in Rhode Island: Toward a More Inclusive Behavioral Healthcare System (Mental Health Association of Rhode Island)
- Disparities in Health and Social Outcomes For LGBTQ+ Students in Rhode Island, 2022 (BHDDH)

[ix] Note: List captures the majority of resources reviewed, but is not exhaustive. Specific sources used in this report are cited throughout the document.

- Driving Under the Influence in Rhode Island Data Brief, April 2022 (BHDDH, RI DOT)
- FCCP Annual Report: Opening to DCYF within 24 Months, Entry Cohort FY 18-20, N=4,347 (Rhode Island Department of Children, Youth, & Families)
- Healthy Aging Data Report: Highlights from Rhode Island, 2020 (UMass Boston)
- HSTP Healthcare Survey for Deaf and Hard of Hearing Individuals 2020 (RI Commission on the Deaf and Hard of Hearing)
- Local Area Unemployment Statistics: Labor Market Information June 2022 - June 2023 (Rhode Island Department of Labor and Training)
- Long Term Care Service and Finance Performance Report, April 2021 (Executive Office of Health & Human Services (State of Rhode Island Executive Office of Health and Human Services)
- Maternal and Child Health (MCH) Report to Legislature, February 2022 (Rhode Island Department of Health)
- Maternal and Child Health Services Title V Block Grant, Rhode Island, FY 2023 Application/FY 2021 Annual Report (Rhode Island Department of Health/Maternal and Child Health Services)
- Multilingual Learners in Rhode Island Issue Brief, February 2023 (Rhode Island KIDS COUNT)
- National Youth in Transition Databases (NYTD) Report: Entry Cohorts of Children in Rhode Island Foster Care FFY14, FFY17, FFY20 (Rhode Island Department of Children, Youth, & Families)
- Network Adequacy: A Survey of Rhode Island's Behavioral Health Provider Network 2021 (Mental Health Association of Rhode Island)
- Opioid Overdose Integrated Surveillance System Report (Rhode Island Department of Health)
- Racial and Ethnic Disparities in Children's Economic Well-Being Issue Brief, December 2021 (Rhode Island KIDS COUNT)
- Racial and Ethnic Disparities in K-16 Education in Rhode Island Issue Brief, January 2023 (Rhode Island KIDS COUNT)
- Racial and Ethnic Disparities in Maternal, Infant, and Young Children's Health in Rhode Island Issue Brief, January 2023 (Rhode Island KIDS COUNT)
- RIVETS Annual Report 2022 (State of Rhode Island Office of Veterans Services)
- Recidivation Among Youth Entering the Rhode Island Juvenile Justice System, FY18-21: Descriptive Statistics (Rhode Island Department of Children, Youth, & Families)
- Rhode Island Behavioral Health System of Care Plan for Children and Youth, March 2022 (Executive Office of Health and Human Services)
- Rhode Island Behavioral Health System Review Technical Assistance Final Report, July 2021 (Faulkner Consulting Group, Health Management Associates, EOHHS)
- Rhode Island Department of Children, Youth, & Families Safety Report, FFY20-FFY2022 (Rhode Island Department of Children, Youth, & Families)
- Rhode Island Department of Children, Youth, & Families Permanency Report: Entry Cohort of Children in Foster Care FY15-FY20 (Rhode Island Department of Children, Youth, & Families)
- Rhode Island Department of Children, Youth, & Families Strategic Metrics Dashboard, 2023 (Rhode Island Department of Children, Youth, & Families)
- Rhode Island Department of Corrections Calendar Year 2022 Population Update (Rhode Island Department of Corrections)
- Rhode Island Department of Corrections Fiscal Year 2022 Annual Report (Rhode Island Department of Corrections)

- Rhode Island Department of Human Services Office of Rehabilitation Services and Rhode Island State Rehabilitation Council 2022 Annual Report (Rhode Island Department of Human Services/Office of Rehabilitation Services, Rhode Island State Rehabilitation Council)
- Rhode Island's Harm Reduction Center Pilot Program (Prevent Overdose RI, Rhode Island Department of Health)
- Rhode Island's Health Assessment July 2022 (Rhode Island Department of Health)
- Rhode Island Health Insurance Survey (HIS): 2020 Executive Summary Report (Rhode Island Executive Office of Health and Human Services, HealthSourceRI, & Freedman HealthCare)
- Rhode Island: HIV, Sexually Transmitted Infections, Viral Hepatitis, and Tuberculosis Surveillance Report, 2021 (Rhode Island Department of Health)
- Rhode Island Medicaid Managed Care Program All Medicaid Managed Care Plans: 2021 External Quality Review Annual Technical Report, April 2023 (IPRO prepared on behalf of The State of Rhode Island Executive Office of Health and Human Services)
- Rhode Island Title IV-B FFY 2023 Annual Progress and Services Report (Rhode Island Department of Children, Youth, & Families)
- Root Causes of Overweight and Obesity: Community-Driven Solutions to Address Racial and Ethnic Disparities in Rhode Island, June 2023 (Rhode Island KIDS COUNT)
- Summary Findings and Recommendations from Community Needs Assessment, State of Rhode Island to the Rhode Island Community Action Association (RICAA), May 2022 (Seeds for Change, LLC, State of Rhodes Island CAPs/Rhode Island Community Action Association)
- The State of Behavioral Healthcare in Rhode Island 2020 Report (Mental Health Association of Rhode Island)
- The Stigma of Substance Use: Its Impact and What You Can Do, September 2022 Community Overdose Engagement (CODE) Technical Assistance Workshop (Rhode Island Department of Health/Division of Community Health and Equity)
- Health Facts RI
- KIDS COUNT Community Profiles
- Prevent Overdose RI
- Prevent Suicide RI
- Rhode Island BRFSS
- Rhode Island Department of Health: Drug Overdose Surveillance Data Hub
- Rhode Island Emergency Department Surveillance of Nonfatal Suicide-Related Outcomes (RI ED-SNSRO)
- RI Health Food Pantries and Soup Kitchens
- RIDOH Hospital Discharge Data
- RI Department of Labor & Training data
- RI Coalition to End Homelessness Point-In Time 2023 Tableau Dashboard

National Data Sources

- American Community Survey (ACS) 5-year data 2017-2021
- Bureau of Labor Statistics unemployment data coupled with RI Department of Labor & Training data
- Centers for Disease Control and Prevention

- Area Deprivation Index
- County Health Rankings data on Black-White residential segregation
- FBI Crime Data Explorer (coupled with data from the RIDOC report)
- Feeding America food insecurity data
- KIDS COUNT city-specific data provided by Rhode Island on WIC
- Military One Source supported by DOD
- MIT Living Wage calculator
- Sentencing Project detailed data tool
- Southern Poverty Law Center Hatewatch

Appendix C: Provider Survey

Community Needs Assessment 2023 Survey

A community needs assessment must be conducted in 2023 as part of the State's SAMHSA grant requirements. As part of this assessment, we would like to hear from you specifically. In particular, we would like your perspective on reaching individuals who face barriers that prevent them from obtaining needed services.

Please note that we will not quote you or share your completed survey with anyone. The survey will take you approximately 15 minutes to complete. We appreciate your time and will reach out to you about the overall findings to get your assessment on anything that may have been missed. Reach out to Palmira Santos at psantos@brandeis.edu with any questions.

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1. Please share the following general information about yourself:

- ○ Name: _____
- ○ Organization you work for: _____
- ○ Role in organization: _____
- ○ Town(s) you work in: _____
- ○ Email address: _____
- ○ Phone number: _____

2. What type of organization do you work for? (Select all that apply.)

- ☐ Peer-run and operated service provider
- ☐ Community mental health or substance use treatment provider
- ☐ Residential program
- ☐ Juvenile justice agency or facility
- ☐ Criminal justice agency or facility
- ☐ Indian Health Service or other tribal program
- ☐ Child welfare agency or child placing agency for therapeutic foster care service
- ☐ Crisis response agency (such as emergency department, crisis stabilization, crisis call center)

- [ ] Specialty provider of medications for treatment of opioid and alcohol use disorders
- [ ] Homeless shelter or housing agency
- [ ] Employment services provider
- [ ] Older adult services provider (such as Area Agency on Aging)
- [ ] Aging and Disability Resource Center
- [ ] Other (please specify) _____

Please complete the following questions based on your specific role, not the organization's scope of services.

2. What services do you provide? (Select all that apply.)

- [ ] Substance use services
- [ ] Counseling
- [ ] Education services
- [ ] Housing services
- [ ] Job training and employment services
- [ ] Law enforcement
- [ ] Mental health services
- [ ] Case management
- [ ] Peer services
- [ ] Medical services
- [ ] Local government
- [ ] Other services (please specify) _____

3. Which of the following groups do you provide services for? (Select all that apply.)

- [ ] Seniors (ages 65 and over)
- [ ] Adults
- [ ] Transition age youth (ages 18 to 25)
- [ ] Children
- [ ] Families
- [ ] Caregivers

4. Which of the following special populations do you work with? (Select all that apply.)

- ☐ Aging/elderly people
- ☐ Individuals in the criminal justice system
- ☐ Individuals with HIV/AIDS
- ☐ Individuals with intellectual or developmental disabilities
- ☐ Individuals with mental health issues
- ☐ People with substance use disorders
- ☐ Other individuals (please specify) _____
- ☐ Low-income individuals
- ☐ People who are homeless
- ☐ Uninsured individuals
- ☐ Veterans
- ☐ Active military personnel
- ☐ LGBTQ individuals

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5. In your perspective, which individuals **need the most help** in your region? (Select all that apply.)

- ☐ Black individuals
- ☐ American Indian/Alaska Native individuals
- ☐ Latino/a/x individuals
- ☐ Transition age youth (i.e., youth 18 to 25 years old)
- ☐ Aging/elderly people
- ☐ Individuals with intellectual or developmental disabilities
- ☐ Individuals involved with the criminal justice system
- ☐ Individuals with HIV/AIDS
- ☐ Individuals with mental health issues
- ☐ Individuals with substance use disorders
- ☐ Domestic violence survivors
- ☐ Asian/Pacific Islander individuals
- ☐ Other people of color
- ☐ Children
- ☐ LGBTQ individuals
- ☐ Low-income individuals
- ☐ People who are homeless
- ☐ Uninsured individuals
- ☐ Underinsured individuals
- ☐ Veterans
- ☐ Active military personnel
- ☐ Other individuals (please specify) _____

6. Are there specific cultural and/or language groups that **especially need help** in your region?

_____

_____

_____

7. In your perspective, what barriers prevent individuals from accessing needed services?

_____

_____

_____

8. Thinking about the challenges in your region, please indicate the level of access and quality for each service type. (Select all that apply.)

	Limited or No Access	Quality Concerns	No Access or Quality Concerns	Unsure
Crisis 24-hour mobile stabilization services	☐	☐	☐	☐
Mental health and substance use screening, assessment, and diagnosis	☐	☐	☐	☐
Patient-centered treatment planning	☐	☐	☐	☐
Primary healthcare screening and monitoring	☐	☐	☐	☐
Outpatient mental health and substance use treatment	☐	☐	☐	☐
Substance use harm reduction	☐	☐	☐	☐
Targeted case management	☐	☐	☐	☐

	Limited or No Access	Quality Concerns	No Access or Quality Concerns	Unsure
Psychiatric rehabilitation	☐	☐	☐	☐
Armed forces and veterans services	☐	☐	☐	☐
Peer support services	☐	☐	☐	☐
School-based mental health services	☐	☐	☐	☐
Infant/early childhood mental health services	☐	☐	☐	☐
Wraparound services for children and families (for example, FCCPs)	☐	☐	☐	☐
Care coordination	☐	☐	☐	☐
Support in getting assistance (such as food, housing, protection from violence)	☐	☐	☐	☐

9. How satisfied are you with the range of services for each of the following groups?

	Very Dissatisfied	Somewhat Dissatisfied	Neither Satisfied nor Dissatisfied	Somewhat Satisfied	Very Satisfied	Unsure
Persons with serious mental illness	○	○	○	○	○	○
Persons with substance use disorders	○	○	○	○	○	○
Persons with co-occurring mental health and	○	○	○	○	○	○

	Very Dissatisfied	Somewhat Dissatisfied	Neither Satisfied nor Dissatisfied	Somewhat Satisfied	Very Satisfied	Unsure
substance use disorders						
Children with serious emotional disturbances	○	○	○	○	○	○
Veterans and active military personnel	○	○	○	○	○	○

10. To what extent do you agree that the following barriers prevent people in your region from getting services that they need?

	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree	Unsure
Cultural barriers	○	○	○	○	○	○
Language barriers	○	○	○	○	○	○
Racism and discrimination	○	○	○	○	○	○
Stigma	○	○	○	○	○	○
Criminalization and/or aggressive policing	○	○	○	○	○	○
Neighborhood violence	○	○	○	○	○	○
Confidentiality concerns	○	○	○	○	○	○
Food insecurity	○	○	○	○	○	○
Homelessness	○	○	○	○	○	○

	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree	Unsure
Lack of affordable housing	○	○	○	○	○	○
Lack of awareness on how to get assistance	○	○	○	○	○	○
Lack of a living wage	○	○	○	○	○	○
Lack of health insurance	○	○	○	○	○	○
Inadequate health insurance	○	○	○	○	○	○
Lack of public transportation	○	○	○	○	○	○
Not enough available appointments	○	○	○	○	○	○
Not enough evening/ weekend hours	○	○	○	○	○	○
Inadequate quality of care	○	○	○	○	○	○

11. Are there barriers not listed above that prevent people in your region from getting needed services?

_____

_____

_____

12. Of all the barriers you have identified, which do you think are hardest to overcome?

_____

_____

_____

13. In your region, which groups **face the most barriers** to accessing needed, high-quality services? (Select all that apply.)

- ☐ Black individuals
- ☐ American Indian/Alaska Native individuals
- ☐ Latino/a/x individuals
- ☐ Asian/Pacific Islander individuals
- ☐ Other people of color
- ☐ Children
- ☐ Transition age youth (i.e., youth 18 to 25 years old)
- ☐ Aging/elderly people
- ☐ Individuals with intellectual or developmental disabilities
- ☐ Individuals involved with the criminal justice system
- ☐ Individuals with HIV/AIDS
- ☐ Individuals with mental health issues
- ☐ Individuals with substance use disorders
- ☐ Domestic violence survivors
- ☐ LGBTQ individuals
- ☐ Low-income individuals
- ☐ People who are homeless
- ☐ Uninsured individuals
- ☐ Underinsured individuals
- ☐ Veterans
- ☐ Active military personnel
- ☐ Other individuals (please specify)

_____

14. In your region, are there specific cultural and/or language groups that are **especially likely to face barriers** to accessing needed, high-quality services?

_____

_____

_____

15. If you work in more than one location, are there any notable differences in client needs or barriers between those locations? If so, please describe.

_____

_____

_____

16. Please share any additional comments on barriers to accessing high-quality behavioral health, physical health, and economic and social services.

_____

_____

_____

Thank you for taking the time to complete our survey!
Your response has been recorded.

This survey was adapted from a survey developed by Trebuchet Research, LLC, and Community Healthcore.

Appendix D: Supplementary Tables and Figures

Table D1. Demographic Comparison of CCBHC Regions, Rhode Island Overall, and the United States

	Northern RI # (%)	Pawtucket Region # (%)	Providence Region # (%)	Johnston/ West # (%)	Kent Region # (%)	Washington Region # (%)	Bristol/ East Bay # (%)	Newport Region # (%)	Rhode Island Overall # (%)	United States # (%)
Total population	130,368	97,392	188,812	192,929	169,345	129,735	97,843	85,525	1,091,949	329,725,481
Sex										
Female	66,768 (51.2)	48,181 (49.5)	97,504 (51.6)	98,625 (51.1)	86,820 (51.3)	66,705 (51.4)	49,897 (51.0)	43,166 (50.5)	557,666 (51.1)	166,518,816 (50.5)
Male	63,600 (48.8)	49,211 (50.5)	91,308 (48.4)	94,304 (48.9)	82,525 (48.7)	63,030 (48.6)	47,946 (49.0)	42,359 (49.5)	534,283 (48.9)	163,206,615 (49.5)
Age (years)										
Under 18	27,692 (21.2)	22,576 (23.2)	40,203 (21.3)	37,019 (19.2)	31,864 (18.8)	21,248 (16.4)	17,804 (18.2)	14,257 (16.7)	212,663 (19.5)	74,234,075 (22.5)
18-64	80,620 (61.8)	63,609 (65.3)	126,855 (67.2)	120,111 (62.3)	105,547 (62.3)	81,221 (62.6)	60,706 (62.0)	52,031 (60.8)	690,700 (63.3)	202,602,785 (61.4)
65 and older	22,056 (16.9)	11,207 (11.5)	21,754 (11.5)	35,799 (18.6)	31,934 (18.9)	27,266 (21.0)	19,333 (19.8)	19,237 (22.5)	188,586 (17.3)	52,888,621 (16.0)
Race/Ethnicity										
White, non-Hispanic	100,721 (77.3)	39,455 (40.5)	64,345 (34.1)	146,710 (76.0)	146,674 (86.6)	117,327 (90.4)	83,161 (85.0)	72,307 (84.5)	770,700 (70.6)	196,010,370 (59.4)
Hispanic or Latino	14,630 (11.2)	34,809 (35.7)	81,002 (42.9)	23,476 (12.2)	9,852 (5.8)	4,511 (3.5)	5,266 (5.4)	5,127 (6.0)	178,673 (16.4)	60,806,969 (18.4)
Mexican	1,054 (7.2)	2,741 (7.9)	2,521 (3.1)	1,378 (5.9)	1,176 (11.9)	1,173 (26.0)	715 (13.6)	863 (16.8)	11,621 (6.5)	36,983,682 (60.8)
Puerto Rican	8,039 (54.9)	10,661 (30.6)	14,894 (18.4)	4,799 (20.4)	3,501 (35.5)	1,086 (24.1)	1,897 (36.0)	2,210 (43.1)	47,087 (26.4)	5,857,466 (9.6)
Cuban	41 (0.3)	203 (0.6)	530 (0.7)	231 (1.0)	458 (4.6)	163 (3.6)	308 (5.8)	86 (1.7)	2,020 (1.1)	2,369,179 (3.9)
Dominican	1,863 (12.7)	4,388 (12.6)	38,627 (47.7)	7,294 (31.1)	1,587 (16.1)	379 (8.4)	947 (18.0)	466 (9.1)	55,551 (31.1)	2,203,172 (3.6)
Central American	866 (5.9)	9,551 (27.4)	16,581 (20.5)	5,714 (24.3)	1,297 (13.2)	617 (13.7)	363 (6.9)	624 (12.2)	35,613 (19.9)	5,791,215 (9.5)

	Northern RI # (%)	Pawtucket Region # (%)	Providence Region # (%)	Johnston/ West # (%)	Kent Region # (%)	Washington Region # (%)	Bristol/ East Bay # (%)	Newport Region # (%)	Rhode Island Overall # (%)	United States # (%)
South American	1,861 (12.7)	6,001 (17.2)	4,783 (5.9)	2,633 (11.2)	1,084 (11.0)	516 (11.4)	654 (12.4)	442 (8.6)	17,974 (10.1)	4,068,949 (6.7)
Other Hispanic or Latino	906 (6.2)	1,264 (3.6)	3,066 (3.8)	1,427 (6.1)	749 (7.6)	577 (12.8)	382 (7.3)	436 (8.5)	8,807 (4.9)	3,533,306 (5.8)
Black or African American, non-Hispanic	3,591 (2.8)	12,633 (13.0)	24,593 (13.0)	7,878 (4.1)	3,006 (1.8)	1,266 (1.0)	2,971 (3.0)	3,265 (3.8)	59,203 (5.4)	40,196,302 (12.2)
Asian, non-Hispanic	5,422 (4.2)	1,556 (1.6)	11,234 (5.9)	7,699 (4.0)	5,115 (3.0)	2,511 (1.9)	2,421 (2.5)	1,185 (1.4)	37,153 (3.4)	18,554,697 (5.6)
American Indian and Alaska Native, non-Hispanic	59 (0.2)	199 (0.2)	916 (0.5)	150 (0.08)	232 (0.1)	818 (0.6)	61 (0.06)	333 (0.4)	2,968 (0.3)	1,936,842 (0.6)
Native Hawaiian and Other Pacific Islander, non-Hispanic	0 (0.0)	46 (0.05)	368 (0.2)	98 (0.05)	19 (0.01)	8 (0.01)	0 (0.0)	0 (0.0)	539 (0.05)	555,712 (0.2)
Some other race, non-Hispanic	644 (0.5)	3,091 (3.2)	1,280 (0.7)	833 (0.4)	539 (0.3)	272 (0.2)	914 (0.9)	460 (0.5)	8,033 (0.7)	1,208,267 (0.4)
Two or more races, non-Hispanic	5,101 (3.9)	5,593 (5.7)	5,074 (2.7)	6,085 (3.2)	3,908 (2.3)	3,022 (2.3)	3,049 (3.1)	2,848 (3.3)	34,680 (3.2)	10,456,322 (3.2)
Place of birth										
US Born	117,284 (90.0)	70,462 (72.3)	130,919 (69.3)	171,238 (88.8)	157,030 (93.1)	123,668 (95.3)	85,048 (86.9)	80,059 (93.6)	936,369 (85.8)	284,880,673 (86.4)
Foreign Born	13,084 (10.0)	26,950 (27.7)	57,893 (30.7)	21,691 (11.2)	11,634 (6.9)	6,067 (4.7)	12,795 (13.1)	5,466 (6.4)	155,580 (14.2)	44,844,808 (13.6)
Language Spoken at Home*										
Only English	99,648 (81.3)	49,353 (54.1)	90,052 (50.8)	150,164 (81.6)	146,282 (90.7)	117,826 (94.3)	76,578 (82.0)	74,508 (91.0)	804,411 (77.6)	243,098,950 (78.3)
Other than English	22,987 (18.7)	41,801 (45.9)	87,249 (49.2)	33,913 (18.4)	14,916 (9.3)	7,149 (5.7)	16,777 (18.0)	7,376 (9.0)	232,168 (22.4)	67,203,410 (21.7)
Spanish	9,114 (39.6)	26,167 (62.6)	66,455 (76.2)	16,695 (49.2)	4,995 (33.5)	1,940 (27.1)	3,492 (20.8)	2,592 (35.1)	131,450 (56.6)	41,157,140 (61.2)
Speak English less than very well	3,179 (34.9)	10,641 (40.7)	31,237 (47.0)	5,747 (34.4)	1,915 (38.3)	865 (44.6)	733 (21.0)	940 (36.3)	55,257 (42.0)	16,079,944 (39.1)

	Northern RI # (%)	Pawtucket Region # (%)	Providence Region # (%)	Johnston/ West # (%)	Kent Region # (%)	Washington Region # (%)	Bristol/ East Bay # (%)	Newport Region # (%)	Rhode Island Overall # (%)	United States # (%)
Other Indo-European languages	9,660 (42.0)	13,340 (31.9)	10,529 (12.1)	9,664 (28.5)	6,079 (40.8)	3,265 (45.7)	11,655 (69.5)	3,745 (50.8)	67,937 (29.3)	11,525,491 (17.2)
Speak English less than very well	2,691 (27.9)	5,784 (43.4)	2,366 (22.5)	2,173 (22.5)	1,514 (24.9)	839 (25.7)	3,954 (33.9)	729 (19.5)	20,050 (29.5)	3,497,837 (30.3)
Asian and Pacific Island languages	3,104 (13.5)	997 (2.4)	6,707 (7.7)	5,250 (15.5)	3,454 (23.2)	1,696 (23.7)	1,435 (8.6)	659 (8.9)	23,302 (10.0)	10,906,763 (16.2)
Speak English less than very well	957 (30.8)	487 (48.8)	2,409 (35.9)	2,372 (45.2)	1,179 (34.1)	859 (50.6)	541 (37.7)	217 (32.9)	9,021 (38.7)	4,875,197 (44.7)
Other languages	1,109 (4.8)	1,297 (3.1)	3,558 (4.1)	2,304 (6.8)	388 (2.6)	248 (3.5)	195 (1.2)	380 (5.2)	9,479 (4.1)	3,614,016 (5.4)
Speak English less than very well	312 (28.1)	358 (27.6)	1,050 (29.5)	918 (39.8)	56 (14.4)	25 (10.1)	26 (13.3)	173 (45.5)	2,918 (30.8)	1,082,281 (29.9)
Veteran status**										
Veteran	6,647 (6.5)	2,927 (3.9)	3,494 (2.4)	8,853 (5.7)	11,027 (8.0)	7,462 (6.9)	4,905 (6.1)	6,751 (9.9)	52,066 (6.0)	17,431,290 (6.9)
Non-veteran	95,936 (93.5)	71,863 (96.1)	144,962 (97.6)	146,995 (94.3)	126,150 (92.0)	100,406 (93.1)	75,025 (93.9)	61,545 (90.1)	822,889 (94.0)	236,864,889 (93.2)
Military status†										
Active-duty military	—	—	—	—	—	—	—	—	3,262	1,335,848
Disability status††										
With a disability	20,913 (16.2)	14,798 (15.3)	25,413 (13.6)	23,580 (12.5)	25,088 (14.9)	13,676 (10.6)	11,739 (12.1)	9,627 (11.8)	144,834 (13.5)	38,327,157 (14.8)
No disability	108,044 (83.8)	81,666 (84.7)	161,105 (86.4)	165,160 (87.5)	143,121 (85.1)	114,805 (89.4)	84,938 (87.9)	72,196 (88.2)	931,035 (86.5)	220,914,393 (85.2)
LGBT Identity‡										
LGBT	—	—	—	—	—	—	—	—	9.0%	8.2%
Non-LGBT	—	—	—	—	—	—	—	—	86.7%	87.5%
Other	—	—	—	—	—	—	—	—	4.3%	4.3%

Source, except where otherwise stated: American Community Survey, 2021 5-Year Estimates (Tables B03001, B05002, B21001, DP05, S1601, and S1811).

** The denominator for this group is the population aged 5+, so percentages are calculated using this denominator (not shown) and not the total population reflected in the table.*

*** The denominator for this group is the population aged 18+, so percentages are calculated using this denominator (not shown) and not the total population reflected in the table.*

† Data are for 2021. Source: U.S. Department of Defense. 2021 Demographics: Profile of the Military Community. https://download.militaryonesource.mil/12038/MOS/Reports/2021-demographics-report.pdf

†† The denominator for this group is the total civilian noninstitutionalized population, so percentages are calculated using this denominator (not shown) and not the total population reflected in the table.

‡ Data are for 2021 and the denominator is individuals aged 18+. Note that these data are experimental. Sources: U.S. Census Bureau. (2021, November 04). Sexual Orientation and Gender Identity in the Household Pulse Survey. https://www.census.gov/library/visualizations/interactive/sexual-orientation-and-gender-identity.html; U.S. Census Bureau. Household Pulse Survey Data Tables (weeks 34-37). Retrieved October 2023 from https://www.census.gov/programs-surveys/household-pulse-survey/data.html

Table D2. Social and Economic Comparison of Rhode Island CCBHC Regions

	Northern RI # (%)	Pawtucket Region # (%)	Providence Region # (%)	Johnston/ West # (%)	Kent Region # (%)	Washington Region # (%)	Bristol/East Bay # (%)	Newport Region # (%)	Rhode Island Overall # (%)
Total Population	130,368	97,392	188,812	192,929	169,345	129,735	97,843	85,525	1,091,949
Poverty Status in Past 12 Months									
Population where poverty status is estimated	128,585 (98.6)	96,153 (98.7)	173,952 (92.1)	185,081 (95.9)	167,921 (99.2)	123,924 (95.5)	93,427 (95.3)	81,471 (95.3)	1,050,314 (96.2)
Below federal poverty level	13,057 (10.2)	16,448 (17.1)	37,402 (21.5)	13,663 (7.4)	12,909 (7.7)	9,875 (8.0)	8,174 (8.8)	6,729 (8.3)	118,257 (11.3)
Above federal poverty level	115,528 (89.8)	79,705 (82.9)	136,550 (78.5)	171,418 (92.6)	155,012 (92.3)	114,049 (92.0)	85,073 (91.2)	74,742 (91.7)	932,057 (88.7)
Food Stamps/SNAP									
Total households	49,835	36,760	67,974	74,773	71,737	50,838	39,543	35,329	426,769
Receiving SNAP	7,329 (14.7)	8,719 (23.7)	19,546 (28.8)	8,275 (11.1)	8,830 (12.3)	3,283 (6.5)	3,876 (9.8)	2,953 (8.4)	62,811 (14.7)
With children under 18	2,999 (40.9)	3,710 (42.6)	8,619 (44.1)	2,774 (33.5)	3,029 (34.3)	1,329 (40.5)	1,046 (27.0)	1,025 (34.7)	24,531 (39.1)
No children under 18	4,330 (59.1)	5,009 (57.4)	10,927 (55.9)	5,501 (66.5)	5,801 (65.7)	1,954 (59.5)	2,830 (73.0)	1,928 (65.3)	38,280 (60.9)
Not receiving SNAP	42,506 (85.3)	28,041 (76.3)	48,428 (71.2)	66,498 (88.9)	62,907 (87.7)	47,555 (93.5)	35,667 (90.2)	32,376 (91.6)	363,958 (85.3)
Women & Children Participating in WIC*									
Estimated eligible	4,629	6,218	13,009	5,634	4,117	2,127	2,256	1,610	39,843
Estimated enrolled	1,802 (38.9)	2,516 (40.5)	6,387 (49.1)	2,088 (37.1)	1,291 (31.4)	558 (26.2)	746 (33.1)	634 (39.4)	16,022 (40.2)
Education**									
Less than high school degree	12,184 (11.8)	16,117 (21.5)	21,420 (14.4)	13,370 (8.6)	10,557 (7.6)	6,137 (5.7)	8,806 (11)	4,060 (5.7)	92,651 (10.5)
High school degree	51,257 (49.9)	39,603 (52.9)	77,753 (52.3)	81,360 (52.2)	69,612 (50.6)	49,298 (45.5)	36,342 (45.4)	28,335 (39.8)	433,560 (49.3)
College degree or higher	39,235 (38.2)	19,096 (25.5)	49,463 (33.3)	61,180 (39.2)	57,313 (41.6)	53,052 (48.9)	34,891 (43.6)	38,873 (54.5)	353,075 (40.2)

Source, except where otherwise stated: American Community Survey, 2021 5-Year Estimates (Tables B15001, DP05, S1701, and S2201).

** Data as of June 2022. Source: Rhode Island KIDS COUNT. (2023). 2023 Rhode Island KIDS COUNT Factbook.*
https://www.rikidscount.org/Portals/0/2023%20Factbook%20Files/2023_Factbook.pdf?ver=2023-05-10-100640-057
*** The denominator for this group is the population aged 18+, so percentages are calculated using this denominator (now shown) and not the total population reflected in the table.*

Table D3. Food Insecurity in Rhode Island, by County

	Providence County	Kent County	Bristol County	Washington County	Newport County	Rhode Island Overall
Food Insecurity						
Food-insecure population	61,520	12,690	3,020	7,340	5,930	102,130
Above SNAP threshold	35%	42%	57%	44%	49%	52%
Below SNAP, other nutrition programs threshold	65%	58%	43%	56%	51%	48%
Food insecurity rate among:*						
Overall population	9.4%	7.5%	6.0%	5.7%	6.9%	9.3%
Children, <18	14.4%	8.7%	4.2%	6.3%	9.3%	12.9%
Seniors, 60+	—	—	—	—	—	5.2%
White, non-Hispanic individuals	8.0%	6.0%	5.0%	5.0%	6.0%	7.0%
Hispanic or Latino individuals	16.0%	11.0%	14.0%	13.0%	14.0%	15.0%
Black or African American individuals, all ethnicities	19.0%	9.0%	14.0%	24.0%	27.0%	18.0%

Source: Feeding America. Map the Meal Gap. Retrieved September 2023 from https://map.feedingamerica.org/
** Data on food insecurity among Asian, Native American or Alaskan Native, Native Hawaiian or Other Pacific Islander, and multiracial individuals is not available.*

Table D4. Health Insurance in Rhode Island, by County

	Providence County # (%)	Kent County # (%)	Bristol County # (%)	Washington County # (%)	Newport County # (%)	Rhode Island Overall # (%)
Total population	628,878	163,449	48,649	125,901	80,780	1,047,657
Insurance Coverage						
Private	282,309 (44.9)	94,972 (58.1)	28,787 (59.2)	71,359 (56.7)	33,430 (41.4)	510,856 (48.8)
Medicaid	207,378 (33.0)	27,645 (16.9)	7,486 (15.4)	17,046 (13.5)	18,058 (22.4)	277,613 (26.5)
Medicare	104,935 (16.7)	31,964 (19.6)	9,307 (19.1)	28,491 (22.6)	16,311 (20.2)	191,010 (18.2)
Military	11,492 (1.8)	6,136 (3.8)	— (5.8)	7,171 (5.7)	10,295 (12.7)	37,896 (3.6)
Uninsured	22,764 (3.6)	2,731 (1.7)	— (0.5)	— (1.5)	2,686 (3.3)	30,282 (2.9)
Reasons for uninsurance (among those who are uninsured)*						
Job loss	25.4	33.0	100.0	22.1	23.7	26.5
Reduction in hours	13.6	22.0	0.0	23.7	0.0	13.8
Employer stopped offering	14.7	27.8	0.0	4.0	3.0	14.1
Premium too high	22.2	40.9	0.0	22.1	29.6	24.4
Lost Medicaid**	29.3	22.5	0.0	47.4	29.5	29.7

Source: HealthSourceRI. 2022 Health Insurance Survey. https://app.powerbigov.us/view?r=eyJrIjoiNzk2MzQ3MDUtYWM3ZC00Y2NkLTgyMzAtN2VkODBmNDlmM2IyIiwidCI6IjUyY2E2YTU0LTQ0NjUtNDYzNS1iZmYzLTY1ZDBhODQxMjI4OCJ9

** Note: Respondents could select more than once answer, so the total may exceed 100% and counts are not provided.*

*** The data source notes that due to the COVID-19 emergency, all Medicaid coverage in effect or beginning after March 18, 2020, remained active throughout the emergency unless the enrollee died, moved out of state, or requested to end their coverage. The answer choice "Lost Medicaid" is based on respondent answers, but does not match known enrollment trends for Rhode Island Medicaid.*

Table D5. Insurance Status of Rhode Islanders by CCBHC Region and Selected Demographic Categories, 2022

	White, non-Hispanic # (%)	Hispanic or Latino # (%)	Black, non-Hispanic # (%)	Asian, non-Hispanic # (%)	Born in US # (%)	Born outside US # (%)
Total Population						
Providence County	374,047	147,665	42,101	26,020	510,818	117,973
Kent County	140,426	10,930	3,487	4,036	154,954	8,495
Bristol County	40,715	3,095	—	2,035	45,310	3,339
Washington County	113,099	6,025	2,072	2,097	119,349	6,553
Newport County	68,607	3,024	5,426	2,215	74,787	5,993
Rhode Island Overall	736,895	170,739	53,364	36,403	905,217	142,353
Private Insurance						
Providence County	205,670 (55.0)	28,085 (19.0)	17,800 (42.3)	18,947 (72.8)	245,543 (48.1)	36,678 (31.1)
Kent County	81,779 (58.2)	6,078 (55.6)	1,789 (51.3)	3,588 (88.9)	90,386 (58.3)	4,586 (54.0)
Bristol County	26,487 (65.1)	951 (30.7)	— (—)	— (53.8)	26,709 (58.9)	2,077 (62.2)
Washington County	64,992 (57.5)	2,187 (36.3)	1,882 (90.9)	1,661 (79.2)	68,395 (57.3)	2,964 (45.2)
Newport County	30,769 (54.8)	— (21.2)	4,171 (6.1)	1,687 (76.2)	31,884 (42.6)	1,546 (25.8)
Rhode Island Overall	409,697 (55.6)	37,942 (22.2)	21,805 (40.9)	26,977 (74.1)	462,918 (51.1)	47,851 (33.6)
Medicaid						
Providence County	80,081 (21.4)	89,985 (60.9)	15,726 (37.4)	4,314 (16.6)	154,291 (30.2)	53,087 (45.0)
Kent County	22,767 (16.2)	3,380 (30.9)	— (42.9)	— (18.0)	25,779 (16.6)	1,866 (22.0)
Bristol County	4,480 (11.0)	— (65.9)	— (88.7)	— (35.3)	6,807 (15.0)	— (20.3)
Washington County	14,198 (12.6)	2,848 (47.3)	— (—)	— (—)	15,518 (13.0)	— (23.3)
Newport County	11,645 (17.0)	— (43.2)	— (76.9)	— (—)	15,301 (20.5)	— (46.0)
Rhode Island Overall	133,171 (18.1)	99,560 (58.3)	21,642 (40.6)	5,032 (13.8)	217,696 (24.0)	59,917 (42.1)
Medicare						
Providence County	73,015 (19.5)	16,018 (10.8)	5,723 (13.6)	— (4.5)	86,416 (16.9)	18,519 (15.7)
Kent County	27,939 (19.9)	— (8.5)	— (2.5)	— (4.4)	30,579 (19.7)	1,385 (16.3)
Bristol County	8,950 (22.0)	— (3.4)	— (11.3)	— (10.9)	8,725 (19.3)	— (17.4)
Washington County	26,676 (23.6)	— (5.5)	— (9.1)	— (20.8)	27,063 (22.7)	1,429 (21.8)
Newport County	15,607 (22.7)	— (8.4)	— (5.2)	— (7.6)	15,132 (20.2)	— (19.7)
Rhode Island Overall	152,187 (20.7)	17,638 (10.3)	6,313 (11.8)	2,173 (6.0)	167,915 (18.5)	23,095 (16.2)
Military Insurance						
Providence County	8,238 (2.2)	— (0.6)	— (1.6)	— (2.6)	10,682 (2.1)	— (0.7)

	White, non-Hispanic # (%)	Hispanic or Latino # (%)	Black, non-Hispanic # (%)	Asian, non-Hispanic # (%)	Born in US # (%)	Born outside US # (%)
Kent County	6,136 (4.4)	— (—)	— (—)	— (—)	6,136 (4.0)	— (—)
Bristol County	— (1.3)	— (—)	— (—)	— (—)	— (6.2)	— (—)
Washington County	6,411 (5.7)	— (4.4)	— (—)	— (—)	6,539 (5.5)	— (9.6)
Newport County	9,077 (13.2)	— (21.3)	— (—)	— (—)	10,226 (13.7)	— (1.2)
Rhode Island Overall	30,394 (4.1)	1,852 (1.1)	— (1.3)	— (1.8)	36,385 (4.0)	— (1.1)
Uninsured						
Providence County	7,043 (1.9)	12,639 (8.6)	2,164 (5.1)	— (3.5)	13,885 (2.7)	8,879 (7.5)
Kent County	1,804 (1.3)	— (5.0)	— (3.3)	— (6.7)	2,074 (1.3)	— (7.7)
Bristol County	— (0.7)	— (—)	— (—)	— (—)	— (0.6)	— (—)
Washington County	— (0.7)	— (6.4)	— (—)	— (—)	— (1.5)	— (—)
Newport County	— (2.2)	— (5.9)	— (11.8)	— (16.2)	2,244 (3.0)	— (7.4)
Rhode Island Overall	11,445 (1.6)	13,748 (8.1)	2,917 (5.5)	— (4.3)	20,303 (2.2)	9,979 (7.0)

Source: HealthSourceRI. 2022 Health Insurance Survey. https://app.powerbigov.us/view?r=eyJrIjoiNzk2MzQ3MDUtYWM3ZC00Y2NkLTgyMzAtN2VkODBmNDlmM2IyIiwidCI6IjUyY2E2YTU0LTQ0NjUtNDYzNS1iZmYzLTY1ZDBhODQxMjI4OCJ9

Table D6. Number of Discharges with Mental Diseases & Disorders as Major Diagnoses for Hospitalizations in Rhode Island Hospitals and Crude Rate (per 1,000 for each demographic)

	2018	2019	2020	2021	2022
Overall	11,869 (11.23)	12,144 (11.46)	10,767 (10.19)	10,644 (9.72)	11,090 (10.12)
Gender					
Female	5,854 (10.81)	5,727 (10.56)	5,227 (9.67)	5,344 (9.56)	5,438 (9.73)
Male	6,013 (11.66)	6,415 (12.40)	5,537 (10.72)	5,296 (9.87)	5,647 (10.52)
Race/Ethnicity					
Black, Non-Hispanic	1,160 (18.80)	1,200 (19.61)	1,005 (20.32)	979 (19.80)	1,096 (22.16)
Hispanic	1,521 (9.04)	1,580 (9.15)	1,379 (7.34)	1,540 (8.20)	1,708 (9.10)
Other, Non-Hispanic	523 (7.23)	598 (7.93)	514 (4.95)	560 (5.39)	510 (4.91)
White, Non-Hispanic	8,092 (10.72)	8,414 (11.22)	7,546 (10.00)	7,244 (9.60)	7,306 (9.68)
Age					
5-14	568 (5.07)	666 (5.96)	647 (5.52)	723 (6.16)	710 (6.05)
15-19	718 (9.62)	633 (8.83)	706 (9.42)	897 (11.97)	779 (10.39)
20-24	620 (8.21)	630 (8.49)	515 (6.68)	489 (6.34)	470 (6.09)
25-34	1,385 (9.46)	1,433 (9.67)	1,176 (7.99)	1,092 (7.42)	1,147 (7.79)
35-64	3,698 (8.98)	3,866 (9.39)	3,402 (7.98)	2,911 (6.83)	3,065 (7.19)
65+	1,092 (5.98)	1,178 (6.29)	1,094 (5.46)	1,128 (5.63)	1,131 (5.65)

Source: Rhode Island Department of Health. (Updated June 2023). Hospital Discharge Data. https://health.ri.gov/data/hospitalization/discharge/

Notes: Number of discharges are based on Rhode Island Department of Health data. Population data uses American Community Survey (ACS) 1-Year Estimates for each demographic for 2018, 2019, and 2021. While ACS data for 2020 is experimental, 2020 1-year estimates were used for the overall population and gender in that year. For the other 2020 population numbers, 2021 1-year estimates were used, because the 2020 estimation methodology utilized different demographic groupings for race/ethnicity and age. The 2021 1-year estimates were also used for the 2022 population numbers because the 2022 estimates were not yet available at the time of calculation. The crude rates are shown in parentheses; these rates are the number of discharges per 1,000 people within each demographic group. Rates generally decreased in 2020, likely due to the COVID-19 pandemic, but started to increase again from 2021-2022 for most groups. However, those decreases were not observed among non-Hispanic Black individuals or among 15-19-year-olds, for whom rates were generally higher than other groups for race/ethnicity and age, respectively.

Table D7. Number of Discharges with Alcohol/Drug Use & Alcohol/Drug Induced Organic Mental Disorders as Major Diagnoses for Hospitalizations in Rhode Island Hospitals and Crude Rate (per 1,000 for each demographic)

	2018	2019	2020	2021	2022
Overall	5,244 (4.96)	5,185 (4.89)	5,100 (4.82)	5,205 (4.75)	5,309 (4.85)
Gender					
Female	1,548 (2.86)	1,589 (2.93)	1,510 (2.79)	1,472 (2.63)	1,528 (2.73)
Male	3,695 (7.16)	3,596 (6.95)	3,589 (6.95)	3,733 (6.96)	3,781 (7.05)
Race/Ethnicity					
Black, Non-Hispanic	310 (5.03)	310 (5.07)	320 (6.47)	266 (5.38)	347 (7.02)
Hispanic	562 (3.34)	643 (3.72)	524 (2.79)	610 (3.25)	692 (3.69)
Other, Non-Hispanic	189 (2.61)	161 (2.13)	164 (1.58)	214 (2.06)	149 (1.44)
White, Non-Hispanic	3,961 (5.25)	3,979 (5.30)	4,003 (5.31)	4,025 (5.33)	3,966 (5.26)
Age					
5-14	—	—	—	—	—
15-19	20 (0.27)	16 (0.22)	22 (0.29)	13 (0.17)	19 (0.25)
20-24	190 (2.52)	144 (1.94)	126 (1.63)	82 (1.06)	69 (0.89)
25-34	814 (5.56)	807 (5.45)	846 (5.75)	804 (5.46)	726 (4.39)
35-64	2,643 (6.42)	2,737 (6.65)	2,725 (6.39)	2,810 (6.59)	2,860 (6.71)
65+	293 (1.60)	275 (1.47)	283 (1.41)	316 (1.58)	291 (1.45)

Source: Rhode Island Department of Health. (Updated June 2023). Hospital Discharge Data. https://health.ri.gov/data/hospitalization/discharge/

Notes: Number of discharges are based on Rhode Island Department of Health data. Population data uses American Community Survey (ACS) 1-Year Estimates for each demographic for 2018, 2019, and 2021. While ACS data for 2020 is experimental, 2020 1-year estimates were used for the overall population and gender in that year. For the other 2020 population numbers, 2021 1-year estimates because were used, the 2020 estimation methodology used different demographic groupings for race/ethnicity and age. The 2021 1-year estimates were also used for the 2022 population numbers because the 2022 estimates were not yet available at the time of calculation. The crude rates are shown in parentheses; these rates are the number of discharges per 1,000 people within each demographic group. Rates are generally higher for male than female individuals, and are higher among 25-34- and 35-64-year-olds than other age groups. Rates are also higher for non-Hispanic Black and non-Hispanic White individuals than for Hispanic individuals and non-Hispanic individuals of other races.

Table D8. Treatment Episode Data Set (TEDS) Admissions Substance Use Data and Crude Rates (per 1,000 in Population in each demographic)

	2018	2019	2020	2021	2022
Alcohol Only	2,681 (2.5)	2,831 (2.7)	3,771 (3.6)	2,685 (2.5)	2,298 (2.1)
Gender					
Female	850 (1.6)	948 (1.7)	1,109 (2.1)	899 (1.6)	768 (1.4)
Male	1831 (3.5)	1883 (3.6)	2,662 (5.2)	1,786 (3.3)	1,530 (2.9)
Unknown	—	—	—	—	—
Race/Ethnicity					
Black/African American	177 (2.5)	167 (2.4)	223 (3.2)	129 (2.4)	147 (2.4)
American Indian or Alaska Native	19 (4.4)	23 (5.3)	26 (6.0)	19 (5.8)	23 (5.2)
Asian/Native Hawaiian/Other Pacific Islander	27 (0.7)	20 (0.5)	38 (1.0)	27 (0.8)	21 (0.5)
White	2,201 (2.6)	2,372 (2.8)	3,149 (3.8)	2,239 (2.9)	1,843 (2.4)
Unknown Race	257 (4.3)	252 (4.2)	339 (5.7)	271 (2.8)	264 (3.0)
Hispanic/Latinx	201 (1.2)	207 (1.2)	272 (1.6)	204 (1.1)	202 (1.1)
Not Hispanic/ Latinx	2391 (2.7)	2,282 (2.6)	3,368 (3.8)	2,406 (2.7)	2,020 (2.2)
Unknown Ethnicity	88	339	132	75	76
Age					
<18	0	3	4	0	2
18-65	2,619	2,763	3,632	2,604	2,227
66+	62	65	136	81	69
Alcohol w/ Secondary Drug	1731 (1.6)	1,875 (1.8)	2,062 (2.0)	1,437 (1.3)	1,004 (0.9)
Gender					
Female	473 (0.9)	459 (0.8)	553 (1.1)	356 (0.7)	273 (0.5)
Male	1,258 (2.4)	1,416 (2.7)	1,509 (2.8)	1,081 (1.9)	731 (1.3)
Unknown	—	—	—	—	—
Race/Ethnicity					
Black/African American	175 (2.5)	227 (3.2)	217 (3.1)	152 (2.8)	104 (1.7)
American Indian or Alaska Native	14 (3.2)	17 (3.9)	25 (5.8)	19 (5.8)	14 (3.1)
Asian/Native Hawaiian/Other Pacific Islander	9 (0.2)	24 (0.6)	14 (0.4)	7 (0.2)	11 (0.3)
White	1,361 (1.6)	1,393 (1.6)	1,524 (1.8)	1,096 (1.4)	742 (1.0)
Unknown Race	175 (2.9)	214 (3.6)	282 (4.8)	162 (1.7)	133 (1.5)
Hispanic/Latinx	138 (0.8)	173 (1.0)	217 (1.3)	138 (0.7)	107 (0.6)
Not Hispanic/ Latinx	1,539 (1.7)	1,513 (1.7)	1,740 (2.0)	1,234 (1.4)	847 (0.9)
Unknown Ethnicity	54	189	105	65	50
Age					
<18	5	4	4	0	3

	2018	2019	2020	2021	2022
18-65	1,721	1,860	2,050	1,428	990
66+	5	11	6	10	11
Heroin	4,007 (3.8)	3,461 (3.3)	2,631 (2.5)	1,673 (1.5)	879 (0.8)
Gender					
Female	1,306 (2.4)	1,125 (2.1)	892 (1.7)	452 (0.8)	283 (0.5)
Male	2,701 (5.2)	2,336 (4.5)	1,739 (3.2)	1,221 (2.2)	596 (1.1)
Unknown	—	—	—	—	—
Race/Ethnicity					
Black/African American	156 (2.2)	138 (2.0)	92 (1.3)	72 (1.3)	47 (0.8)
American Indian or Alaska Native	16 (3.7)	14 (3.2)	5 (1.2)	3 (0.9)	4 (0.9)
Asian/Native Hawaiian/Other Pacific Islander	20 (0.5)	24 (0.6)	21 (0.6)	3 (0.1)	6 (0.2)
White	3,262 (3.8)	2,793 (3.3)	2,115 (2.5)	1,317 (1.7)	659 (0.9)
Unknown Race	553 (9.3)	491 (8.2)	397 (6.7)	278 (2.9)	163 (1.9)
Hispanic/Latinx	517 (3.1)	446 (2.6)	366 (2.2)	259 (1.4)	140 (0.7)
Not Hispanic/ Latinx	3,418 (3.8)	2,918 (3.3)	2,231 (2.5)	1,390 (1.5)	723 (0.8)
Unknown Ethnicity	72	97	34	23	16
Age					
<18	0	0	0	0	0
18-65	3,991	3,447	2,615	1,665	861
66+	16	17	13	10	16
Other Opiates	1,969 (1.9)	2,335 (2.2)	3,072 (2.9)	2,825 (2.6)	2,666 (2.4)
Gender					
Female	652 (1.2)	808 (1.5)	1,075 (2.1)	890 (1.7)	909 (1.7)
Male	1,317 (2.6)	1,527 (3.0)	1,997 (3.7)	1,935 (3.5)	1,757 (3.1)
Unknown	—	—	—	—	—
Race/Ethnicity					
Black/African American	87 (1.2)	126 (1.8)	157 (2.3)	178 (3.3)	155 (2.6)
American Indian or Alaska Native	10 (2.3)	14 (3.2)	25 (5.8)	28 (8.5)	32 (7.2)
Asian/Native Hawaiian/Other Pacific Islander	8 (0.2)	21 (0.6)	15 (0.4)	20 (0.6)	21 (0.5)
White	1,654 (1.9)	1,936 (2.3)	2,476 (3.0)	2,257 (2.9)	2,101 (2.7)
Unknown Race	203 (3.4)	241 (4.0)	402 (6.8)	339 (3.5)	357 (4.1)
Hispanic/Latinx	167 (1.0)	224 (1.3)	375 (2.2)	305 (1.6)	320 (1.7)
Not Hispanic/ Latinx	1,750 (2.0)	1,994 (2.2)	2,642 (3.0)	2,497 (2.8)	2,309 (2.6)
Unknown Ethnicity	51	117	55	23	37

	2018	2019	2020	2021	2022
Age					
<18	0	0	0	0	3
18-65	1,945	2,309	3,057	2,808	2,653
66+	24	23	15	11	13
Cocaine (smoked)	499 (0.5)	539 (0.5)	572 (0.5)	456 (0.4)	348 (0.3)
Gender					
Female	200 (0.4)	202 (0.4)	239 (0.5)	197 (0.4)	148 (0.3)
Male	299 (0.6)	337 (0.7)	333 (0.6)	259 (0.5)	200 (0.4)
Unknown					
Race/Ethnicity					
Black/African American	96 (1.4)	120 (1.7)	93 (1.3)	79 (1.5)	60 (1.0)
American Indian or Alaska Native	3 (0.7)	6 (1.4)	2 (0.5)	6 (1.8)	13 (2.9)
Asian/Native Hawaiian/Other Pacific Islander	5 (0.1)	5 (0.1)	3 (0.1)	2 (0.1)	3 (0.1)
White	326 (0.4)	327 (0.4)	386 (0.5)	297 (0.4)	229 (0.3)
Unknown Race	69 (1.2)	81 (1.4)	88 (1.5)	72 (0.7)	43 90.5)
Hispanic/Latinx	51 (0.3)	61 (0.4)	43 (0.3)	47 (0.3)	27 (0.1)
Not Hispanic/ Latinx	440 (0.5)	439 (0.5)	496 (0.6)	392 (0.4)	313 (0.3)
Unknown Ethnicity	8	39	33	17	8
Age					
<18	0	0	0	0	0
18-65	497	539	571	451	346
66+	1	0	1	5	2
Cocaine (other route)	403 (0.4)	327 (0.3)	312 (0.3)	234 (0.2)	199 (0.2)
Gender					
Female	120 (0.2)	85 (0.2)	80 (0.2)	56 (0.1)	64 (0.1)
Male	283 (0.5)	242 (0.5)	232 (0.4)	178 (0.3)	135 (0.2)
Unknown	—	—	—	—	—
Race/Ethnicity					
Black/African American	68 (1.0)	46 (0.7)	34 (0.5)	25 (0.5)	29 (0.5)
American Indian or Alaska Native	6 (1.4)	5 (1.2)	3 (0.7)	1 (0.3)	4 (0.9)
Asian/Native Hawaiian/Other Pacific Islander	5 (0.1)	4 (0.1)	2 (0.1)	7 (0.2)	0
White	251 (0.3)	212 (0.2)	225 (0.3)	154 (0.2)	125 (0.2)
Unknown Race	73 (1.2)	60 (1.0)	48 (0.8)	47 (0.5)	41 (0.5)
Hispanic/Latinx	76 (0.5)	52 (0.3)	51 (0.3)	45 (0.2)	38 (0.2)
Not Hispanic/ Latinx	322 (0.4)	257 (0.3)	248 (0.3)	173 (0.2)	151 (0.2)

	2018	2019	2020	2021	2022
Unknown Ethnicity	5	18	13	16	10
Age					
<18	—	6	0	0	0
18-65	401	321	312	230	198
66+	1	0	0	4	1

Source: Substance Abuse and Mental Health Services Administration. (2023, June 30). Quick Statistics: Treatment Episode Data Set. https://www.samhsa.gov/data/quick-statistics-results?qs_type=teds

Notes: Number of admissions are based on TEDS Admissions data. Population data uses American Community Survey (ACS) 1-Year Estimates for each demographic for 2018, 2019, 2021, and 2022. While ACS data for 2020 is experimental, the 2020 1-year estimates were used for the overall population and gender in that year. For the other 2020 population numbers, the 2021 1-year estimates were used, because the 2020 estimation methodology used different demographic groupings for race/ethnicity and age. The crude rates are shown in parentheses; these rates are the number of admissions divided by the population number and multiplied by 1,000, thus providing the number of admissions per 1,000 people in Rhode Island.

Table D9. Rhode Island Methadone Receipt Average Annual Crude Rates (per 100,000 in population for each demographic) Across Racial/Ethnic Groups

	2018	2019	2020	2021	2022
Black/African American, Non-Hispanic	290.28	315.00	308.98	289.93	281.45
Hispanic	340.28	353.03	360.95	342.03	334.58
White, Non-Hispanic	659.78	682.85	691.2	673.53	650.15

Source: Prevent Overdose RI. Medication for Opioid Use Disorder Data. Retrieved October 2023 from https://preventoverdoseri.org/medication-for-opioid-use-disorder-data/
Note: Annual rates were calculated by averaging the four quarterly rates reported by Prevent Overdose RI for each year.

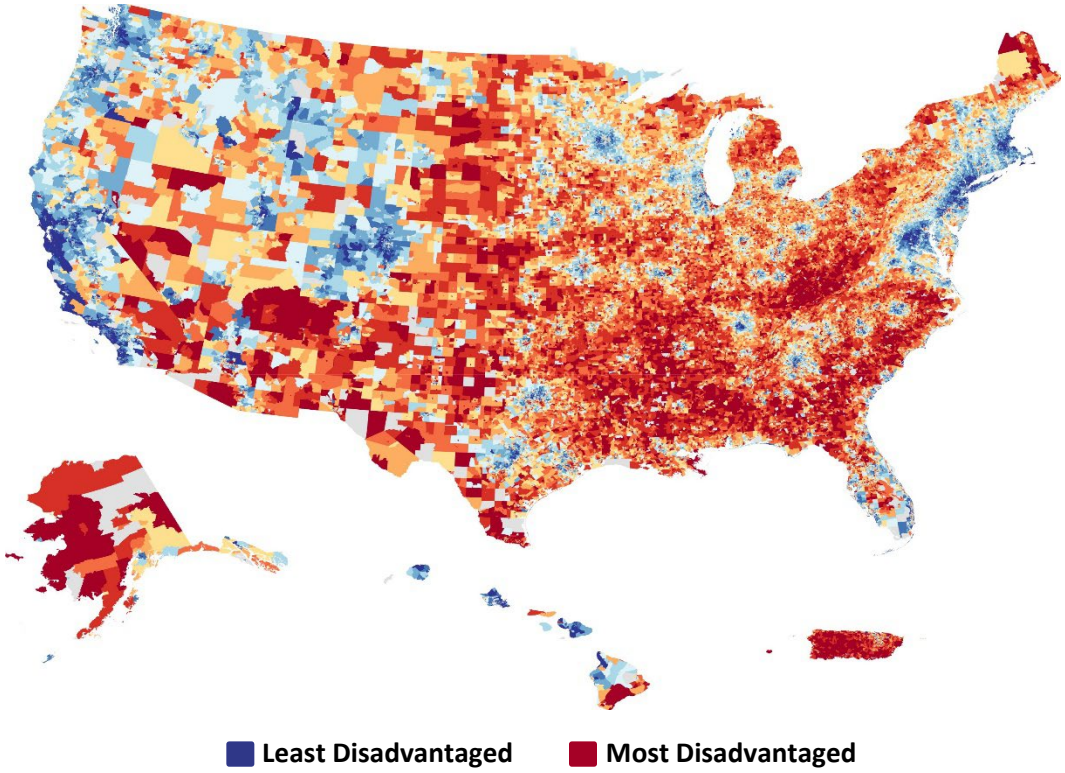
Table D10. Rhode Island Buprenorphine and Methadone Treatment Receipt and Naloxone Distribution Numbers and Rates (per 1,000 in population)

	2018	2019	2020	2021	2022
Buprenorphine	20,785 (19.7)	21, 702 (20.5)	22,337 (21.1)	21,669 (19.8)	21,316 (19.5)
Methadone	23,070 (21.8)	23,776 (22.4)	23,939 (22.6)	24.790 (22.6)	24,022 (22.0)
Naloxone	17,267 (16.3)	21,425 (20.2)	24,773 (23.4)	33,321 (30.4)	53,165 (48.6)

Source: Prevent Overdose RI. Medication for Opioid Use Disorder Data. Retrieved October 2023 from https://preventoverdoseri.org/medication-for-opioid-use-disorder-data/; https://preventoverdoseri.org/naloxone-data/

Notes: Buprenorphine treatment and naloxone distribution numbers include Rhode Island Department of Corrections (RIDOC) individuals. American Community Survey (ACS) 1-Year Estimates were used for population estimates in each year. The crude rates are shown in parentheses; these rates are the number received/distributed divided by the population number and multiplied by 1,000. Rates indicate that buprenorphine and methadone treatment have remained about the same from 2018 to 2022, but naloxone distribution has greatly increased.

Figure D1. 2021 Area Deprivation Index: National Percentiles



Source: University of Wisconsin School of Medicine and Public Health. 2021 Area Deprivation Index. Retrieved October 2023 from https://www.neighborhoodatlas.medicine.wisc.edu/

Figure D2. Groups Needing the Most Help: All Categories