Needs Assessment

RHODE ISLAND FAMILY VISITING

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Rhode Island Family Visiting Needs Assessment Introduction

The following needs assessment conducted for the Rhode Island Family Visiting system, identifies communities with concentrations of risk, assesses the quality and capacity of existing programs in those communities, discusses the state's capacity for providing substance use treatment and recovery services, and describes coordination with other needs assessment efforts. RI will use this needs assessment to inform strategic decision-making, identify opportunities for collaboration, and expand services to at-risk families.

The needs assessment is the result of wide collaborative efforts both within the Rhode Island Department of Health (RIDOH), and with other state agencies and community partners. The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) needs assessment team within the Division of Community, Health, and Equity at RIDOH were responsible for supporting the process and ensuring that the needs assessment used comprehensive and quality data, incorporated community input, and identified needs, that if addressed through new home visiting resources, would result in communities at-risk receiving more comprehensive and coordinated services. In addition, the MIECHV needs assessment team worked closely with the Title V needs assessment team to engage in joint data gathering and data analysis efforts. A more detailed description of our joint data collection efforts with Title V and collaboration with other needs assessments can be found in the last section.

We also worked closely with RI's child welfare agency, the Department of Children, Youth, and Families (DCYF), RI's adult mental health agency, the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH), and the Executive Office of Health and Human Services (EOHHS) which oversees all human service agencies. Collaborating with these agencies allowed us to gather, synthesize, and add context to the initial data we collected. In addition, RIDOH staff conducted individual key informant interviews with staff from BHDDH and EOHHS to gather data and information specifically about maternal substance use. This feedback loop was used to refine and provide further context to the findings. The involvement of other state agencies provided us with a more comprehensive understanding of the current state of family visiting across the state, and a more nuanced perspective on gaps in the system.

Finally, this work was supported by members of the RI Family Visiting Council,[1] the Parent/Caregiver Family Visiting Advisory Council,[2] SISTA FIRE,[3] RI Health Equity Zones,[4] MIECHV Local Implementation Teams, Interagency Coordinating Council (ICC),[5] Successful Start,[6] and the Head Start Directors Association. All of these groups provided input on existing services and unmet needs in RI. At

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[1] *A cross-program/model governance body established in 2019 for family visiting that works to improve coordination across State agencies and family visiting programs*

[2] *An advisory committee of the Family Visiting Council composed of parents/caregivers who have used family visiting services; provides input to goals, policies, priorities, plans, and strategies, especially pertaining to families.*

[3] *A network of womxn of color that engages in participatory action research with their members*

[4] *Rhode Island's Health Equity Zone initiative is a place-based approach that brings communities together to build the infrastructure needed to achieve healthy, systemic changes at the local level. Health Equity Zones are geographic areas where existing opportunities emerge and investments are made to address differences in health outcomes.*

[5] *The ICC is an advisory council to assist EOHHS with program implementation. The council is a venue for information sharing and the council encourages programs to work together on initiatives that are being implemented across the state.*

[6] *Successful Start works to create a comprehensive and coordinated early childhood system that supports families and communities in promoting positive early childhood development so that all children enter school healthy and ready to learn. Successful Start also serves as the Advisory Board for the Rhode Island Department of Health's Healthy Families America Program and the Department of Children, Youth and Families (DCYF) Getting to Kindergarten Initiative.*

various points during the needs assessment process the key emerging themes were shared with agencies, state leaders, and other stakeholders who helped to provide context to what we were learning. Direct input, via surveys and focus groups, from community members and other professionals also informed the work. Finally, KIDSNET, RI's confidential, computerized child health information system and First Connections' Home Visiting database, allowed us to gather program utilization data, and Vital Records data provided maternal and child health status indicators such as entry into prenatal care, low birthweight and infant mortality. KIDSNET provided essential information about indicators for poor outcomes within families and existing home visiting services.

Identifying Communities with Concentrations of Risk

For this needs assessment "community" is defined by city and town. RI has 39 cities and towns. Data collected is most often aggregated at this level and resources are often coordinated at the city and town level. Citizens also identify with the city or town in which they live. Given RI's small size (1.05 million residents) it is possible and more informative to use this unit of analysis to identify the distinct areas and localities at risk as opposed to counties.

Indicators were selected in collaboration with Health Resources and Services Administration (HRSA)/Maternal and Child Health Bureau (MCHB) to match as closely as possible to the statutorily-defined[7] criteria for identifying target communities for home visiting programs. We considered issues such as data availability and reliability of indicators when selecting the final indicator list. After selecting indicators, we grouped them according to five domains (Socioeconomic Status, Adverse Perinatal Outcomes, Substance Use Disorder, Crime, and Child Maltreatment). In addition to the original domains and indicators outlined by HRSA, we have added a health equity domain that reflects RI's local community health priorities. Partners at the Rhode Island Department of Health have established a set of health equity community and environmental indicators which are intended to serve as the statewide standard for assessing the State's progress towards health equity. For the needs assessment we have added the health equity indicators as an additional domain and are utilizing 13 out of 15 indicators for this analysis. We have dropped the measures that were not available at the city and town level.
To analyze the data, we used the simplified algorithm for identifying at-risk counties is as follows:

1. We obtained raw, town-level data for each indicator.
2. We computed the mean of towns and standard deviation (SD) for each indicator as well as other descriptive statistics (number of missing, range, etc.)
3. We standardized the indicator values (compute z-score) for each town so that all indicators have a mean of 0 and a SD of 1. Z-score = (county value - mean)/SD.
4. We used the resulting z-scores for each town to calculate the proportion of indicators within each domain for which that town's z-score was greater than 1, that is, the proportion of indicators for

[7] *Not included are indicators for infant mortality and domestic violence. Infant mortality was excluded from the Adverse Perinatal Outcomes domain because the level of suppression at the county level for 5-year aggregate data was too high for meaningful inclusion (all but 13 states have >50% of counties with suppressed data). Preterm and low birth weight births together are the second largest cause of infant mortality. Given that the other two indicators in the domain are direct precursors of infant mortality, we evaluated the extent to which similar counties were identified when infant mortality rate was included or excluded (among counties with non-suppressed data). The level of suppression for preterm birth and low birthweight was also substantial for individual year data. Thus, we compiled 3-yr and 5-yr aggregated data to obtain reliable estimates for smaller counties. Domestic violence was excluded because there are no national sources available with county-level data for domestic violence.*

which a given town is in the 'worst' 16% of all towns in the state (16% is the percentage of values greater than 1 SD above the mean in the standard normal distribution). If at least half of the indicators within a domain have z-scores greater or equal to 1 SD higher than the mean, then a town is considered at-risk on that domain. The total number of domains at-risk (out of 5) is summed to capture the towns at highest risk across domains. Towns with 2 or more at-risk domains were identified as at-risk.

Based on calculations, Pawtucket, and Woonsocket has six domains with significant z-scores. Providence has five domains, Central Falls had four, West Warwick, and Newport had three, and Warwick, Lincoln, Cranston, North Providence, and Charlestown had two domains with significant z-scores identifying stress factors in its population.

These findings align with the RIDOH's knowledge of the struggles and inequities certain communities face in the state. We had also added Washington County as another at-risk area even though only 1 town in the county, Charlestown, had Z-scores that were greater or equal to 1 SD higher than the mean. Charlestown is a very small community, with a very low birth rate – because of its small size, Charlestown is considered to be a part of a tri-town area with Richmond and Hopkinton. All three towns share a public infrastructure as well as program and services. These towns reside in Washington County which on the whole appears more affluent than most other RI counties and the US in general. However, significant socioeconomic disparity exists, even in the most affluent areas warranting its inclusion on our list of at-risk communities. Please reference the Washington County section below for a more detailed profile of the area.

Z-Scores By Domain - At Risk Communities

City/Town	SES	Adverse Perinatal Outcomes	Substance Use Disorder	Crime	Child Maltreatment	RI Health Equity Indicators	Number of At-Risk Domains
Woonsocket	1.00	0.50	1.00	1.00	1.00	0.50	6
Pawtucket	1.00	1.00	1.00	1.00	1.00	0.58	6
Providence	1.00	1.00	1.00	1.00	0.00	0.67	5
Central Falls	1.00	0.50	0.00	0.50	1.00	0.42	4
West Warwick	0.33	0.50	0.5	0.00	1.00	0.25	3
Newport	0.33	0.50	0.00	0.50	1.00	0.33	3
Warwick	0.00	0.50	1.00	0.00	0.00	0.17	2
Lincoln	0.00	0.50	0.00	0.50	0.00	0.09	2
Cranston	0.00	0.50	0.50	0.00	0.00	0.17	2
North Providence	0.00	1.00	0.00	0.00	1.00	0.25	2
Washington County	0.00	0.00	0.00	0.00	0.00	0.00	0
*Charlestown**	*0.33*	*1.00*	*0.00*	*0.00*	*1.00*	*0.09*	*2*

**Charlestown is a town within Washington County*

Woonsocket

Woonsocket has a population of 41,751. There are 11,155 children (under 18), 46% living in single parent families. Approximately, 7% of children are under the age of 5. Woonsocket is becoming increasingly diverse with 75.3% White, 9.2% Black or African American, 6% Asian, 0.9% American Indian and Alaska Native, and 4.4% mixed race. Over 18% of the population identifies as Hispanic or Latino.[8,9]

Our algorithm identified six areas of stress: socioeconomic status, adverse perinatal outcomes, substance use, child maltreatment, and crime. In addition, Woonsocket scored low on RI's health equity indicators. In Woonsocket, 37.1% of children live in poverty, the highest rate in the state. The unemployment rate is 17.1% and the high school dropout rate is 15%. The median income of families in Woonsocket ($38,340) is significantly lower than the overall state's median income ($61,043). Overall, 41% of households are cost burdened households. Woonsocket also has a significant shortage of safe affordable housing. On average, a family needs an income of $66,950 to affordably purchase a median priced home ($202,750) in this community. A family has to make $47,080 in order to afford the average rent for a 2-bedroom apartment is $1,177. From 2013-2018, the median single-family house price has gone up 50% ($134,738 to 202,750) and the average 2-bedroom rent has gone up by 3% ($1,144 to $1,177).[9,10,11]

In addition, 9.1% infants are born at low birthweight and 9.1% are preterm births. The teen birth rate has dramatically dropped from 113.1 per 1,000 teens in 2010 to 39.9 in 2018 but it is still the highest rate in the state. The rate of delayed prenatal care is 20.7%. The rate of reported crimes/1000 is higher than the state at 28.1/1000 and 21.4 children per 1000 have incarcerated parents. Twenty-six percent of children witnessed a domestic violence incidence in 2017.[10,11] Finally, Woonsocket has one of the highest rates of overdose deaths in the state at 43.3 per 100,000 residents .[12]

Community and stakeholder input reinforced issues of poverty and the lack of affordable and safe housing, limited access to public transportation and inability to meet basic needs, especially during COVID-19. All family visiting programs are available in Woonsocket. For all of the family visiting programs for which eligibility data is available, the need far outweighs the capacity to provide services.

Pawtucket

Pawtucket has a population of 72,117. Just under a quarter of the population (22.6%) is under the age of 18, 43% of these are living in single parent families. Approximately, 6% of children are under the age of 5. The racial makeup of the city is 62.5% White, 18% Black or African American, 0.6% reported as American Indian and Alaska Native, 2% Asian, and 5.2% mixed race. Approximately 49% identify as Hispanic or Latino. The city has significant Portuguese, Cape Verdean, and Liberian populations. [8, 9]

Our algorithm identified six areas of community stress: socioeconomic status, adverse perinatal outcomes, substance use, child maltreatment, and crime. In addition, Pawtucket scored low on RI's health equity indicators. In Pawtucket, 30% of children live in poverty. The unemployment rate is 16.2% and the high school dropout is 11%. The median income of families in Pawtucket ($44,909) is significantly lower than the overall state's median income ($61,043). On average, a family would need an income of $66,240 to affordably purchase a median priced home ($210,000) in this community. A family needs to make $54,960 to afford the average rent for a 2-bedroom apartment, which is $1,394. From 2013-2018, the median

single-family house price has gone up 44% ($145,409 to 210,000) and the average 2-bedroom rent has gone up by 8% ($1,274 to $1,374).[9,10,11]

Like Woonsocket, Pawtucket has high proportions of adverse perinatal outcomes, 8.4% infants are born at low birthweight and 9.4% are preterm births. The teen birth rate is 26.3 per 1,000 teens, which is significantly higher than the state rate of 13.1, and the rate of delayed prenatal care is 19.0%. The rate of reported crimes/1000 residents is higher than the state at 29.3/1000 residents compared to 19.8; and 15.4 children per 1000 have incarcerated parents. Twenty-seven percent of children witnessed a domestic violence incidence in 2017.[11] In addition, Pawtucket has a high rate of overdose deaths compared to other areas in the state (34.4 per 100,000 residents)[12].

Community and stakeholder input also reinforced the issues of poverty and financial insecurity among residents and pointed to a lack of affordable safe housing, linguistic barriers to services, and a lack of transportation and resources available to families. All family visiting programs are available in Pawtucket. For all of the family visiting programs for which eligibility data is available, the need far outweighs the capacity to provide services.

Providence

Providence is the capital of RI with a total population of 179,883 in 2019. There are 45,277 children (under 18), 46% of these are living in single parent families. Approximately, 7% of children are under the age of 5. The racial makeup of the city is 54.2% White, 16% Black or African American, 6.1% Asian, 1.2% American Indian and Alaska Native, 0.2% Native Hawaiian and other Pacific Islander, and 4.4% mixed race. Forty-three percent of the population identify as Hispanic or Latino. Providence has one of the largest Liberian immigrant populations in the country and a significant number of residents from Southeast Asia including Cambodians (1.7%), Chinese (1.1%), Asian Indians (0.7%), Laotians (0.6%), and Koreans (0.6%). There is also a considerable community of immigrants from various Portuguese-speaking countries, especially Portugal, Brazil, and Cape Verde.[8, 9]

Our algorithm identified five areas of community stress: socioeconomic stability, adverse perinatal outcomes, substance use, and crime. In addition, Providence scored low on RI's health equity indicators. In Providence, 34% of children live in poverty. The unemployment rate is 16.6% and the high school dropout is 16% (the second highest in the state). The median income of families in Providence ($37,881) is significantly lower than the overall state's median income ($61,043). Providence also has a shortage of safe affordable housing. On average, a family would need an income of $60,147 to affordably purchase a median priced home ($190,000) in this community. A family would have to make even more money ($70,400) to be able to afford the average 2-bedroom rental ($1,760 a month). Overall, 45% of households are cost burdened households. From 2013-2018, the median single-family house price has gone up 68% ($113,180 to 190,000) and the average 2-bedroom rent has gone up by 3% ($1,707 to $1,760). The largest number of foreclosures in RI is in Providence.[10,11,]

Providence has high proportions of adverse perinatal outcomes; 8.8% infants are born at low birthweight and 9.8% are preterm births. The teen birth rate is 19.3 per 1,000 teens, and the rate of delayed prenatal care is 19.8%. The rate of reported crimes/1000 residents is higher than the state at 38.3/1000; and 20.8 children per 1000 have incarcerated parents. Twenty-nine percent of children witnessed a domestic violence incidence in 2017.[9] Finally, Providence has one the highest rates of overdose deaths in the state (42.3 per 100,000 residents).[12]

Community and stakeholder input pointed to themes of housing insecurity, lack of transportation, access to affordable child care and material resources (diapers, food, car seats, etc.), and financial instability. Although public transportation is more available in Providence, bus routes can be indirect and take too long for families to efficiently get from place to place. All family visiting programs are available in Providence. For all of the family visiting programs for which eligibility data is available, the need far outweighs the capacity to provide services.

Central Falls

Central Falls is the state's smallest city. With an area of only 1.3 square miles, it is also the most densely populated city in RI with a population of 19,568. More than a quarter (28.4%) of the population in the city is under the age of 18, 49% of these are living in single parent families. Approximately, 9% of children are under the age of 5. The racial makeup of the city is 54.5% White, and 13.9% Black or African American, 1.2% American Indian and Alaskan Native, 0.4% Asian, and 5.6% mixed race. Sixty-seven percent identify as Hispanic or Latino.[8,9]

Our algorithm identified four areas of community stress: socioeconomic stability, adverse perinatal outcomes, child maltreatment, and crime. In Central Falls, 44.9% of children live in poverty. The unemployment rate is 17.6% and the high school dropout rate is 19%. The median income of families in Central Falls ($30,754) is significantly lower than the overall state's median income ($61,043). Overall, 55% of all households, in Central Falls, are cost burdened.[8] On average, a family needs an income of $56,400 to affordably purchase a median priced home in this community. The average rent for a 2-bedroom apartment is $1,374. From 2013-2018, the median single-family house price has gone up 49% ($107,251 to $159,950) and the average 2-bedroom rent has gone down by 3% ($1,448 to $1,410). [9,10,11]

In addition, 8.6% infants are born at low birthweight and 10.3% are preterm births, compared to 8.7% statewide. The teen birth rate is 45.1 per 1,000 teens, which is more than triple the state rate of 13.1, and the rate of delayed prenatal care is 19.8%. Thirty-six percent of children witnessed a domestic violence incidence in 2017. The rate of reported crimes/1000 residents is higher than the state at 25.2/1000 compared to 19.8/1000 and 17.7 children per 1000 have incarcerated parents. [9]

Community and stakeholder input also reinforced the challenges of poverty for residents of this area and pointed to other issues such as the marginalization of the undocumented, unsafe and/or high-priced housing, lack of services and resources in different languages, and transportation issues. All family visiting programs are available in Central Falls. For all of the family visiting programs for which eligibility data is available, the need far outweighs the capacity to provide services.

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[8] *Census QuickFacts. https://www.census.gov/quickfacts*
[9] *2020 RI Kids Count Factbook*
[10] *Cost burden, a socioeconomic indicator, is calculated by identifying the percentage of cost-burdened renters and owners for RI cities and towns.*
[11] *2019 Factbook Housing Works RI. https://www.housingworksri.org/Portals/0/Uploads/Documents/2019%20Pages/HFB2019_compressed.pdf http://www.rikidscount.org/Portals/0/Uploads/Documents/Factbook%202020/RIKCFactbook2020.pdf?ver=2020-04-06-084405-867*
[12]*Prevent Overdose RI, Overdose Death Data. https://preventoverdoseri.org/overdose-deaths/*

West Warwick

West Warwick has a population of 28,962. Almost 20% (5,746) of the population are children under age 18, 35% of them live in single parent families. Approximately, 5% of children are under the age of 5. The racial makeup of West Warwick is 90.3% White, 3.1% African American, 0.1% American Indian and Alaska Native, 2.9% Asian, and 2.8% mixed race. Approximately 5.2% of the population identifies as Hispanic or Latino.[8,9]

Our algorithm identified three areas of community stress: adverse perinatal outcomes, child maltreatmentt, and substance use disorder. In West Warwick, 7.7% of births are preterm and 6.7% are low birth weight. The teen birth rate is 24.7 per 1,000 teens. In addition, West Warwick has one of the highest rates of overdose deaths in the state with 32 deaths per 100,000 people. It also has a slightly higher rate of children with incarcerated parents (13.5 children per 1000 children compared to 10.1 statewide), the second highest rate of abuse/neglect (30.3 per 1,000), and high rates of children witnessing domestic violence (26%).[9,12]

Even though West Warwick did not score below average on the socioeconomic status indicator, 18.9% children live in poverty. The median income of families in West Warwick ($51,563) is lower than the overall state's median income ($61,043). There are very few jobs in the area that pay a living wage. The unemployment rate is 13.1%. On average, a family needs an income of $75,490 to affordably purchase a median priced home ($223,500) in this community and a family must make $61,920 to afford the average rent for a 2-bedroom apartment ($1,548). From 2013-2018, the median single-family house price has gone up 35% ($165,458 to $223,500) and the average 2-bedroom rent has gone up by 15% ($1,346 to $1,548). Overall, 39% of households are cost-burdened households.[10,11]

Community members and stakeholders pointed to issues of financial security, lack of affordable and safe housing, limited affordable and quality childcare, transportation issues, food insecurity, and limited interpretation services. They also noted the lack of a strong referral system to connect families to proper services and resources. All family visiting programs are available in West Warwick. For all of the family visiting programs for which eligibility data is available, the need far outweighs the capacity to provide services.

Newport

Newport has a population of 24,334. There are 18,780 children (under 18), 23% living in single parent families. Approximately, 5% of children are under the age of 5. The racial makeup of the city is 83.8% White, 6.4% Black or African American, 2% Asian, 1.0% American Indian and Alaska Native, and 4.4% mixed race. Over 10% of the population identifies as Hispanic or Latino.[8,9]

Our algorithm identified three areas of community stress: adverse perinatal outcomes, child maltreatment, and crime. Over 7% of infants are born at low birthweight and 8.0% are preterm births. The rate of reported crimes/1000 is higher than the state at 34/1000 and 13.5 children per 1000 have incarcerated parents. Twenty-five percent of children witnessed a domestic violence incidence in 2017.[9]

Even though Newport did not score low on socioeconomic status, 23% of children live in poverty. Overall, 37% of total households are cost burdened households. On average, a family needs an income of $ $152,608 to affordably purchase a median priced home in this community. The average rent for a 2-

bedroom apartment is $1,572. From 2013-2018, the median single-family house price has gone up 34% ($420,381 to $563,000) and the average 2-bedroom rent has gone up by 16% ($1,361 to $1,572).[9,10,11]

Community and stakeholder input pointed to limited access to affordable and safe housing, transportation, and mental health services for caregivers and children. Family visiting, within Newport and across the state, struggles to engage and deliver services to communities of color and immigrant and undocumented families. All family visiting programs are available in Newport. For all of the family visiting programs for which eligibility data is available, the need far outweighs the capacity to provide services.

Warwick

Warwick has a population of 81,004. There are 5,119 children (under 18), 42% of them live in single parent families. Approximately, 5% of children are under the age of 5. The racial makeup of the city is 91.5% White, 1.6% Black or African American, 3% Asian, .3% American Indian and Alaska Native, and 2.2% mixed race. Over 5% of the population identified as Hispanic or Latino.[9]

Our algorithm identified two areas of community stress: adverse perinatal outcomes and substance use disorder. In Warwick, 8.2% of births are preterm and 6.4% are low birth weight. In addition, Warwick has a higher number of overdose deaths compared to other towns (26.8 per 100,000 residents) and a slightly higher rate of children with incarcerated parents (13.5 children per 1000 children compared to 10.1 statewide).[9]

Community and stakeholder input pointed to a lack of affordable and safe housing, limited affordable and quality childcare, lack of mental health, substance use, and trauma counseling, transportation barriers, and food insecurity. All family visiting programs are available in Warwick. For all of the family visiting programs for which eligibility data is available, the need far outweighs the capacity to provide services.

Lincoln

Lincoln is emerging as an at-risk community. The population is 32,078. Almost 23% (5,157) of the population are children under age 18, 24% of them live in single parent families. Approximately, 5% of children are under the age of 5. The racial makeup of Lincoln is 92.7% White, 1.4% Black or African American, 2.8% Asian, and 1.4% mixed race. Approximately 5% of the population identifies as Hispanic or Latino.[8,9]

Our algorithm identified two areas of community stress: crime and adverse perinatal outcomes. 5.9% infants are born at low birthweight and 8.5% are preterm births. The rate of delayed prenatal care is 14.6%. The rate of reported crimes/1000 is slightly higher than the state at 19.9/1000 compared to 19.8 and 25% of children witnessed a domestic violence incidence in 2017.[9]

Even though Lincoln did not score below average on the socioeconomic status indicator, community members and stakeholders report pockets of impoverished communities who lack transportation, food, and childcare access. All family visiting programs are available in Lincoln. For all of the family visiting programs for which eligibility data is available, the need far outweighs the capacity to provide services.

Cranston

The population of Cranston is 81,456. Almost 23% (5,157) of the population are children under age 18, 24% of them live in single parent families. Approximately, 6% of children are under the age of 5. The racial makeup of Cranston is 79.8% White, 6.0% African American, 0.4% American Indian and Alaska Native, 6.4% Asian, and 3.6% mixed race. Approximately 15% of the population identifies as Hispanic or Latino.[8,9]

Our algorithm identified two areas of community stress: adverse perinatal outcomes and substance use disorder. In Cranston, 8.8% of births are preterm and 6.9% are low birth weight. In addition, Cranston has a high rate of overdose deaths in the state with 20.3 deaths per 100,000 people.[9]

Even though Cranston did not score below average on the socioeconomic status indicator, community members and stakeholders report pockets of poverty, a lack of social safety net services, unsafe and/or high-priced housing, and unaffordable and/or inaccessible transportation. All family visiting programs are available in Cranston. For all of the family visiting programs for which eligibility data is available, the need far outweighs the capacity to provide services.

North Providence

North Providence is emerging as an at-risk community. The population is 32,078. Seventeen percent (5,514) of the population are children under age 18 and 30% of children live in single parent families. Approximately, 4.3% of children are under the age of 5. The racial makeup of North Providence is 84.1% White, 7.4% Black or African American, 3% Asian, and 3% mixed race. Approximately 11.5% of the population identifies as Hispanic or Latino.[8,9]

Our algorithm identified two areas of community stress: adverse perinatal outcomes and child maltreatment. Approximately 9% infants are born at low birthweight and 9.9% are preterm births. The rate of delayed prenatal care is 14.7%. Twenty-seven percent of children witnessed a domestic violence incidence in 2017 and the rate of child abuse and neglect per 1,000 children is 17%.[8,9]

Community members and stakeholders report pockets of impoverished communities who lack transportation, food, and childcare access. All family visiting programs are available in North Providence. For all of the family visiting programs for which eligibility data is available, the need far outweighs the capacity to provide services.

Washington County/Charlestown

Washington County is a rural region with a population of 125,577. The county is composed of nine towns (Charlestown, Exeter, Hopkinton, Narragansett, New Shoreham, North Kingstown, Richmond, South Kingstown, and Westerly). Approximately, 4% of residents are children under the age of 5. The racial makeup of Washington County is 90.8% White, 1.5% Black or African American, 0.9% American Indian and Alaska Native, 2.0% Asian, and 2.0% mixed race. Approximately 3.4% of the population identifies as Hispanic or Latino. It is also home to the Narragansett Indian Nation reservation located in Charlestown.[8]

We believe it is prudent to acknowledge Washington County, which includes the town of Charlestown, as an at-risk community. When viewed at the county-wide level, Washington County appears more affluent than most other RI counties and the US in general. The median household income in Washington County is high ($78,882), while the percent of people in poverty and households with food stamps/Supplemental Nutrition Assistance Program (SNAP) benefits is low compared to RI and the US. The county unemployment rate is low (2.8%) and the majority of workers (66%) are employed in jobs which typically offer competitive salaries and benefits. However, when reviewed at the town level, socioeconomic disparity exists, even in the most affluent areas. Washington County has the highest median household income in the state, but the second highest percentage of individuals who live in poverty. Blacks/African Americans residing in the county are nearly four times as likely to live in poverty and one-third less likely to have attained a bachelor's degree or higher. In addition, more than 50% of renters and 32% of homeowners are housing burdened (Block Island and Westerly have the highest percentages of housing burdened renters or homeowners).

The mental and behavioral health disorders death rate in Washington County is higher than the nation, and is increasing. The percent of Washington County adults reporting excessive drinking (21.4%) and the percent of driving deaths due to DUI (50.0%) are significantly greater than RI (17.4% and 39.1%) and the nation (18.0% and 29.0%). The mental health hospitalization rate for Black, Non-Hispanic residents is double the rate of hospitalization for White, Non-Hispanic residents. Washington County has a significantly higher rate (133.9 per 10,000 delivery hospitalizations) of newborns having neonatal abstinence syndrome (NAS) than the rest of the state (96.1).

Within Washington County, the town of Charlestown has a high rate of preterm births (11.7%) compared to the state average. In addition, the teen birth rate is 17.2 per 1,000 teens, and the rate of delayed prenatal care is 7.0%. Thirty-five percent of children witnessed a domestic violence incidence in 2017 and the rate of child abuse and neglect per 1,000 children is 15.3%.[8,9] It is also worth noting that Westerly and Hopkinton residents experience some of the greatest socioeconomic disparity in the county. And Westerly is one of 10 cities and towns statewide with the highest incidence of domestic violence in the state.

Community and stakeholders noted the lack of affordable housing, limited transportation, lack of mental health and substance use treatment providers, and limited access to childcare. Stakeholders also reported difficulty gaining the trust and sustaining relationships with leaders of the Narragansett tribe. All family visiting programs are available in Washington County. For all of the family visiting programs for which eligibility data is available, the need far outweighs the capacity to provide services.

Womxn of Color[11]

Womxn of color (WOC) are also a population experiencing stress. SISTA FIRE, a member-led network of womxn of color, gathered the perspectives of womxn of color living in the urban core of Rhode Island (primarily Providence, Pawtucket, and Central Falls). SISTA FIRE uses a participatory research model,

[11] *RIODH seeks to recognize the breadth of gender identities among the Maternal Child Health Populations. This includes individuals who are trans, non-binary, and intersex. However, there are limitations on population-based data reported among these individuals. Throughout this annual report, data are presented as they were originally collected and reported for gender, age, race, and ethnicity. RIDOH recognizes that these categories may not reflect how people and communities define themselves. We acknowledge these limits and strive to use language that is welcoming and inclusive of every Rhode Islander whenever possible such as womxn, womxn of color, and Latinx.*

an approach to research in communities that emphasizes the participation of the womxn of color (WOC) in reflecting and interpreting their own data and solution-building. These findings are grounded with the understanding that structural racism has shaped the inequitable landscape in which WOC exist.[12] SISTA FIRE's data identified the following concerns, feelings, and perceptions among womxn of color:

- ***Racism in Healthcare:*** 2019 SISTA FIRE Survey found that 8% of Womxn of Color (WOC) responded always experiencing racism in the healthcare setting and 49% WOC experienced racism sometimes.
- ***Financial Stability:*** WOC are most concerned about: not enough jobs that pay a living wage or have a career path (52%), paying monthly bills (41%), wealth creation (34%) and debt (32%). Fifty percent of the approximately 300 people who took the survey earned less than $30K, almost a quarter (23.3%) of respondents made an annual income of $10k or less. Forty-nine percent reported that they were unable to save for future or emergency expenses and 23% were unable to make payments towards their debt. High rates of debt are indicators of stress and instability. Debt and credit issues limit access to housing and ability to afford housing, as well as other basic needs like food, healthcare, childcare and transportation.
- ***Educational Advancement:*** WOC struggle to attain higher education degrees due to a lack of financial resources and supports. Sixty-eight percent of WOC reported having to work part or full time to afford basic needs and tuition.
- ***Housing Stability:*** Only 18% of respondents reported ownership of their house. A majority of WOC (66%) rented their homes; many rent in Providence, where there have been steep increases in rents with the average household needing to earn an annual income of $70,400 in order to afford a 2-bedroom apartment.
- ***Food Security:*** A significant percentage of WOC also reported struggling to afford food (31%), housing (48%), and to pay off debt (79%).
- ***Mental Health & Toxic Stress***: Systematic racism and the related inequities and hardships, listed above, contribute to emotional, mental, and toxic stress in WOC. Majority of WOC surveyed (70%) felt the best way to support young children 1-4 years of age was to support the parent/caregiver (socially, emotionally, and financially).

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[12] Structural Racism is defined as a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity (Source: The Aspen Institute. Glossary for Understanding and the Dismantling Structural Racism/Promoting Racial Equity Analysis. https://assets.aspeninstitute.org/content/uploads/files/content/docs/rcc/RCC-Structural-Racism-Glossary.pdf)

Quality and Capacity of Existing Programs

Gaps in the Delivery of Early Childhood Family Visiting Services

Availability of Services and Number of Eligible Families Not Served

The RI Family Visiting system collectively serves approximately 7,700 families in RI each year. Those families are supported by over 100 family visitors across 10 family visiting programs that are delivered by 26 local community agencies across the state. Together, they make approximately 25,000 visits a year. There are several family visiting services available to families in RI, including but not limited to the MIECHV-funded programs: Healthy Families America, Nurse-Family Partnership, Parents as Teachers, as well as Early Intervention, Early Head Start, and several services for children and families involved with the Department for Children, Youth, and Families. In 2019, all of these programs came together to collectively develop a statewide strategic plan and establish a state-level system for family visiting to improve the coordination across state agencies and family visiting programs and more effectively serve families and their children. The section below describes existing family visiting programs and initiatives for early childhood home visitation and the capacity of each program, including an estimate of the number of families not served in each community experiencing stress where data was available.

First Connections (FC)

First Connections is an assessment and referral program for RI children birth to age three who face early adversity and may experience poor developmental outcomes. Families are identified to participate in the program through universal screening at birth, and/or community referrals. First Connections works in conjunction with the state's universal newborn screening program, which identifies babies with medical, social, or economic risk conditions. Managed by RIDOH, First Connections is operated by five community agencies that collectively provide services across all of RI cities and towns.
Home Visiting Model or Approach: Risk assessment through health and home assessment, screenings and referral to appropriate services.
Services Provided: A multidisciplinary team of nurses, social workers, and community health workers provides First Connections services. Most families receive between one to four visits. The teams provide home assessments, connection to community services, and information about child development for almost a quarter of all families with new babies each year. Services include instruction in newborn care, depression screening, assessments of family needs, information on detecting and controlling housing-related health and safety hazards, developmental screening and referrals to community resources such as child care, parenting support, and WIC (Women, Infants, and Children) and Early Intervention.
Recipients of Services: Families with young children birth to three who have one or more of the following risk factors identified at birth: low birth weight, NICU hospitalization more than 48 hours, developmental disability, mother positive for hepatitis B or any 2 of the following: caregiver education less than 11th grade, birth mother's age <19 or >37, single caregiver, less than 6 prenatal care visits before 36 weeks or no prenatal visits before 5 months, gestational age > 37 weeks and low birth weight, Apgar score <7, Medicaid/RIte Care eligible, or parent with chronic illness. Any child under age three years can also be referred to the program for any reason.
Targeted Goals/Outcomes: To improve the health and development of young children and their families through a model of home-based outreach, screening, assessment, referral, and linkage with appropriate programs.

***Demographic Characteristics*:** Families from all over the state accept services. Many live in poverty, have more than one child, and are young mothers.
Number of Families Served: In 2019, there were 9,647 resident births in RI. Of these births 6,144 (64%) screened positive for some level of risk at birth and were referred to First Connections and 2,235 (23%) received at least one visit. Of those that did not have a visit, 30% did not respond to outreach, 48% declined or withdrew from the service before the first visit, 15% were unreachable and 4% were already engaged in a long-term family visiting program.
Geographic Area Served: Statewide
Number of Eligible Families Not Served: The estimate of eligible population for First Connections was calculated by counting the number of newborns with a positive screening at birth for risk factors: Medicaid eligible, under age 21, history of involvement with DCYF, a history of substance use, no high school diploma, developmental disability, enrollment in the armed forces, single, and a history of inpatient or outpatient mental health treatment. The capture rate in Woonsocket, West Warwick, Newport, Lincoln, North Providence, and Washington County is below the average for other at-risk communities as well as the state rate overall. It should also be noted that staff capacity is not at needed levels in Newport, Lincoln and Woonsocket.

First Connections Capture Rate by Town

Community Experiencing Stress	Total Births, 2019	Number of Births with 1 or more Risk Factors, 2019	% Risk Positive	Number Received First Connections Visit in 2019	Capture Rate[13]
Woonsocket	491	398	81%	159	32%
Pawtucket	826	620	75%	311	38%
Providence	1465	1117	76%	835	57%
Central Falls	292	249	85%	160	55%
West Warwick	284	202	71%	101	36%
Newport	219	131	60%	56	26%
Warwick	284	202	71%	152	54%
Lincoln	163	73	45%	29	18%
Cranston	753	440	58%	175	23%
North Providence	312	195	63%	91	29%
Washington County	1083	523	48%	312	29%
Charlestown	*44*	*25*	57%	*13*	30%
Total - At-Risk Communities	**6216**	**4175**	**67%**	**2381**	**38%**
State Overall	**9647**	**6144**	**64%**	**3166**	**33%**

Source: RI Department of Health

Nurse-Family Partnership (NFP)

Nurse-Family Partnership targets low-income, first-time mothers. Trained, bachelor-level registered nurses carry a caseload up to 25 families and conduct frequent home visits during pregnancy until the child's second birthday. Currently, there is one NFP site in RI serving 200 families. Services are statewide,

[13] *% of Total Births That Received A First Connections Visit*

but are prioritized for Providence, Pawtucket, Woonsocket, Central Falls, West Warwick, and Newport families.
Home Visiting Model or Approach: Nurse-Family Partnership Program
Services Provided*:* Visits to pregnant individuals begin bi-weekly to improve pregnancy outcomes by addressing the effects of smoking, alcohol, substance use. Best practices in nutrition and exercise are discussed as are preparation for childbirth, prenatal care, referrals to health and human service providers. After birth, nurse home visitors provide parent education on infants' and toddlers' nutrition, health, growth and development, and environmental safety, family planning, returning to work or school and increasing economic self-sufficiency are also addressed.
Recipients of Services: First time, low-income expectant mothers. Enroll prior to 28 weeks post-gestation.
Targeted Goals /Outcomes*:* Goals of the program are to improve pregnancy outcomes, child health and development, and economic self-sufficiency of the family.
Demographic Characteristics: In 2019, 70% of NFP participants were pregnant individuals and 30% were female caregivers. The majority of participants were under the age of 24, with 14% under 18, 50% between the ages of 18-24 and 7% over the age of 35. Sixty-three percent of participants did not report their race but of those that did, 57% were white, 35% were Black or African American, 4% were Asian, 2% were American Indian or Alaska Native, and 2% were more than one race. Forty-two percent identified as Hispanic or Latino. Sixty-seven percent were single and not living with a partner and 20% were married. Twenty-nine percent did not have a high school diploma, 36% had earned a high diploma or equivalency, and 4% had completed some college. Fifty-seven percent were unemployed and 55% rented their home. Of those that reported their primary language, the majority (65%) spoke English and 29% spoke Spanish. Ninety-four percent of those that reported their income levels, had incomes under 200% of the Federal Poverty level. Twelve percent reported a history of child abuse or neglect or past interactions with child welfare services and 14% reported a history of substance abuse or needs substance abuse treatment.
Number of Families Served: 289 families were enrolled in 2019 and had 2,481 visits. In 2019, NFP was operating at approximately 87% of contracted capacity.
Geographic Area Served: Statewide
Number of Eligible Families Not Served: The estimate of eligible population for Nurse-Family Partnership was calculated by counting the number of first time, low-income mothers with three or more additional risk factors: Medicaid eligible, under age 21, history of involvement with DCYF, a history of substance use, no high school diploma, developmental disability, enrollment in the armed forces, single, and a history of inpatient or outpatient mental health treatment. The capture rate in Woonsocket, West Warwick, Newport, Warwick, Lincoln, Cranston, North Providence, and Washington County is below the average for communities experiencing stress as well as the state rate overall. In addition, the number of people in the target population far outweighs the contracted capacity to provide services making it difficult to improve capture rates without expanded program capacity. Additional contracted slots are needed in Woonsocket, Cranston, Washington County, and Newport.

Nurse Family Partnership Capture Rate By Town

At Risk Community	Target Population: # First Time Mothers, Low Income With 3 or More Other Risk Factors	# Families Enrolled in NFP as of October 2019	Capture Rate[14]
Woonsocket	67	10	15%
Pawtucket	99	28	28%

[14] *% of First Time, Low Income Mothers with 3 or More Risk Factors Enrolled*

At Risk Community	Target Population: # First Time Mothers, Low Income With 3 or More Other Risk Factors	# Families Enrolled in NFP as of October 2019	Capture Rate[14]
Providence	281	89	32%
Central Falls	36	19	53%
West Warwick	23	1	4%
Newport	21	1	5%
Warwick	36	2	6%
Lincoln	5	1	20%
Cranston	56	3	5%
North Providence	20	3	15%
Washington County	45	3	7%
Charlestown	*3*	*0*	0%
Total – At-Risk Communities	**689**	**160**	**23%**
State Overall	**835**	**173**	**21%**

Source: RI KIDSCOUNT 2020 Factbook and the RI Department of Health

Nurse Family Partnership Contracted Slots as a Percent of Target Population By Town

City/Town	Contracted Slots	% Contracted Capacity*	Contract Slots as % of Target Population
Woonsocket and Surrounding Areas**	18	111%	12%
Pawtucket	48	58%	48%
Providence	97	92%	35%
Central Falls	24	79%	67%
West Warwick and Surrounding Areas***	9	44%	11%
Newport County	4	200%	5%
Cranston	0	0%	0%
Washington County****	0	0%	0%
Statewide TOTAL	**200**	**87%**	**24%**

**Note: NFP contract slots are focused on areas which in some cases encompass more than 1 town. As a result, contracted slots cannot be analyzed strictly by town. For example, contracted slots for Woonsocket include Woonsocket and surrounding areas but contracted slots for Pawtucket are only for Pawtucket.*
***Includes North Providence, Lincoln, and Woonsocket*
****Includes West Warwick and Warwick*
*****Includes Charlestown*
Source: RI Department of Health

Healthy Families America (HFA)

Healthy Families America aims to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. In RI, HFA services begin prenatally or immediately following the birth of a baby and are offered voluntarily and intensively until the baby turns four years of age. Managed by RIDOH, Healthy Families America is operated by nine community agencies that collectively provide services across all

Rhode Island cities and towns, prioritizing Providence, Pawtucket, Woonsocket, Central Falls, Westerly (in Washington County), Cranston, West Warwick, Newport, and East Providence.
Home Visiting Model or Approach: Healthy Families America Program
Services Provided: Services include assessment and screening for perinatal depression, substance use, and domestic violence, prenatal guidance, parenting support and guidance, care coordination.
Recipients of Services: Expectant parents and parents/caregivers with children under three months of age may enroll. The primary participant may be the mother, father, or whoever has long term care of the child. To be eligible, the primary caregiver must complete a Parent Survey (a tool that was developed by Dr. Henry Kempe) that assesses the parent across 10 domains. The domains range from how parents were raised, if they have lifelines, their stressors, plans for discipline, and perceptions of their newborn/expectant child.
Targeted Goals/Outcomes: Goals of the program are to promote and strengthen positive parent-child relationships, promote positive growth and development in children, and build the strengths of families and their protective factors.
Demographic characteristics: In 2019, 79% of HFA participants were female caregivers and 20% were pregnant individuals. Three percent were under 17, 30% were between 18 and 14, 46% of participants were between the ages 24 and 34 and 20% were 35 or older. Thirty percent of participants did not report their race but of those that did, 58% were white, 30% were Black or African American, 2% were Asian, 2% were American Indian or Alaska Native, and 9% were more than one race. Forty-six percent identified as Hispanic or Latino. Fifty percent were single and not living with a partner and 24% were married. Twenty-nine percent did not have a high school diploma, 35% had earned a high diploma or equivalency, and 12% had completed some college. Sixty percent were unemployed, 54% rented their home and 3% were homeless. Of those that reported their primary language, the majority (59.5%) spoke English, 31% spoke Spanish, 4.6% spoke Cape Verdean Creole, and 1.2% spoke Portuguese. Ninety-three percent of those that reported their income levels, had incomes under 200% of the Federal Poverty level. Thirty-one percent reported a history of child abuse or neglect or past interactions with child welfare services and 18% reported a history of substance abuse or needs substance abuse treatment.
Number of Families Served: A total of 709 families were enrolled between October 2018 and 2019. In 2019, HFA was operating at approximately 89% of contracted capacity.
Geographic Area Served: Statewide
***Number of Eligible Families Not Served*:** The estimate of eligible population for Healthy Families America was calculated by counting the number of repeat mothers with a history of inpatient or outpatient mental health treatment and two of more of the following risk factors: Medicaid eligible, under age 21, history of involvement with the DCYF, a history of substance use, no high school diploma, developmental disability, enrollment in the armed forces, and single. The capture rate in Woonsocket, West Warwick, Newport, Warwick, and North Providence is significantly below the average for communities experiencing stress as well as the state rate overall. To improve capture rates, expanded program capacity is needed – especially in West Warwick and surrounding areas where enrollment as a percent of contracted slots is 117%.

Healthy Families America Capture Rate By Town

At Risk Community	Target Population: Repeat Births with 3 or More Risk Factors and mental health diagnosis	# Families Enrolled in HFA as of October 2019	Capture Rate[15]
Woonsocket	112	51	46%

[15] *% of Mothers with Repeat Births and 3 or More Risk Factors Enrolled in HFA*

At Risk Community	Target Population: Repeat Births with 3 or More Risk Factors and mental health diagnosis	# Families Enrolled in HFA as of October 2019	Capture Rate[15]
Pawtucket	99	100	101%
Providence	309	270	87%
Central Falls	48	45	94%
West Warwick	50	25	50%
Newport	24	12	50%
Warwick	46	29	63%
Lincoln	6	5	83%
Cranston	69	49	71%
North Providence	21	10	48%
Washington County	76	55	72%
Charlestown	*6*	*5*	83%
Total – At-Risk Communities	**860**	**656**	76%
State Overall	**1043**	**709**	68%

Source: RI KIDSCOUNT 2020 Factbook and the RI Department of Health

Healthy Families America Contracted Slots as a Percent of Target Population By Town

City/Town	Contracted Slots	% Contracted Capacity*	Contract Slots as % of Target Population
Woonsocket and Surrounding Areas	105	80%	50%
Pawtucket	105	95%	106%
Providence	360	75%	117%
Central Falls	50	90%	104%
West Warwick and Surrounding Areas	60	117%	47%
Newport County	60	78%	58%
Cranston	60	82%	87%
Washington County	50	88%	66%
Statewide TOTAL	**850**	**83%**	**81%**

**Enrollment as a percent of contracted capacity in an area*
Source: RI Department of Health

Parents as Teachers (PAT)

Parents as Teachers promotes the optimal early development, learning and health of children by supporting and engaging their parents and caregivers. In Rhode Island, PAT services begin prenatally or immediately following the birth of a baby and are offered voluntarily and intensively until the baby turns 4 years of age (some programs serve families with children up to age 5). Managed by RIDOH, PAT is operated by eight community agencies that collectively provide services across all RI cities and towns, prioritizing

Providence, Pawtucket, Woonsocket, Central Falls, Westerly (in Washington County), Cranston, West Warwick, Newport, Bristol, East Providence, Warren, and North Kingstown.

Home Visiting Model: Parents as Teachers

Services Provided: Parents as Teachers parents receive information and support they need to give their child the best possible start in life. PAT services include home visits, group meetings, screenings, and resource networks.

***Recipients of Services**:* Expectant parents and parents/caregivers with children under two years of age may enroll (with funding from RIDOH; some school departments that have funding from their district enroll children up to age three).

Targeted Goals/Outcomes: To increase parent knowledge of early childhood development and improve parenting practices, detect developmental delays and health issues early, prevent child abuse and neglect, and increase children's school readiness and success.

Demographic Characteristics: In 2019, 89% of PAT participants were female caregivers and 3% were male caregivers and 8% were female caregivers. The majority (53%) of participants were between the ages 24 and 34, 27% were 35 or older, 13% were between 18 and 24, and 2% were under 17. Twenty-four percent of participants did not report their race but of those that did, 72% were white, 20% were Black or African American, 3% were Asian, and 5% were more than one race. Forty-four percent were Hispanic or Latino. Thirty-one percent were never married and not living with a partner. Twenty-one percent did not have a high school diploma, 32% had earned a high diploma or equivalency, and 16% had a bachelor's degree or higher. Fifty percent were unemployed, 51% rented their home and 2% were homeless. Of those that reported their primary language, the majority (53%) spoke English, 38% spoke Spanish, 3.4% spoke Cape Verdean Creole, and 2.2% spoke Chinese. Fifty-four percent of those that reported their income levels, had incomes under 200% of the Federal Poverty level. Twenty-two percent reported having someone in the household with low student achievement or a child with low student achievement. Sixteen percent reported a history of child abuse or neglect or past interactions with child welfare services and 15% reported a history of substance abuse or needs substance abuse treatment.

Number of Families Served: Between October 2018 and 2019, a total of 412 families were enrolled in Parents as Teachers. In 2019, PAT was operating at approximately 87% of contracted capacity.

Geographic Area Served: PAT is available in most of the communities at risk including Central Falls, Pawtucket, Providence, Cranston, Newport, Warwick, West Warwick, and Woonsocket as well as parts of Washington County (Charlestown, Coventry, Hopkinton, Richmond, Middletown, North Kingstown and Westerly). It is also available in Scituate, Smithfield, Warren, Bristol, and East Providence.

Number of Eligible Families not Served: The estimate of target population for PAT was calculated by counting the number of repeat mothers with three of more of the following risk factors: Medicaid eligible, under age 21, history of involvement with DCYF, a history of substance use, no high school diploma, developmental disability, enrollment in the armed forces, single, and a history of inpatient or outpatient mental health treatment. The capture rate in Woonsocket, Providence, West Warwick, and Lincoln is significantly below the average for communities experiencing stress as well as the state rate overall. This is primary due to program capacity. A high-level review of 2019 contracted slots indicated that additional PAT slots were needed in Providence, Central Falls, Woonsocket, West Warwick and Warwick, Newport, and Westerly. To address this, RI used Preschool Development Grant funds to add another 300 slots across these localities in summer 2020.

Parents as Teachers Capture Rate By Town

At Risk Communities	Target Population: Repeat Births with 3 or More Risk Factors	# Families Enrolled in PAT as of October 2019	Capture Rate[16]
Woonsocket	147	31	21%
Pawtucket	146	41	28%
Providence	495	93	19%
Central Falls	84	27	32%
West Warwick	55	5	9%
Newport	36	10	28%
Warwick	54	24	44%
Lincoln	9	1	11%
Cranston	85	32	38%
North Providence	23	9	39%
Washington County	92	60	65%
Charlestown	*9*	*0*	0%
Total – At-Risk Communities	**1226**	**333**	**27%**
State Overall	**1438**	**412**	**29%**

Source: RI KIDSCOUNT 2020 Factbook and the RI Department of Health

Early Head Start (EHS)

Early Head Start is a comprehensive early childhood program serving low-income children prenatal to age three, pregnant individuals, and their families. EHS programs nurture healthy attachments between parent and child (and child and caregiver). There are four Early Head Start grantees in the state that offer home-based services. Pregnant individuals enrolled in Early Head Start are assessed for risks to a successful pregnancy. Individualized plans are developed to support prenatal health, promote healthy behaviors, and prepare for a baby's arrival. After the baby is born, families participate by enrolling in a center or home-based program. Home-based programs use weekly home visits to support child development and family engagement and twice-monthly group meetings.

Home Visiting Model or Approach: All Early Head Start providers use an evidence-based curriculum model required by the Head Start Program Performance Standards, which require a low caseload (10-12 families), a weekly 1 ½ hour visit with the parent/legal guardian and bi-monthly socializations for children and parents. Specific curriculum choices are determined at the program level to best meet the needs of the community.

Services Provided: Children receive comprehensive services that address the education, health, and emotional growth of the child. Services provided include physical health, dental health, mental health, and nutrition. In addition, Early Head Start provides intensive social services, parent education programs, and opportunities for parents to become actively involved in the Head Start program.

Recipients of Services: Pregnant individuals and children up to age 3 with income below the federal poverty level ($20,420 for a family of three in 2017), children involved with DCYF, families that receive SSI or Temporary Assistance to Needy Families (TANF), and homeless families.

Targeted Goals/Outcomes*:* In a home-based setting, the foundation of the program is supporting parents as they provide nurturing, responsive, and effective interactions, and engaging environments. EHS home

[16] *% of Repeat Births with 3 or More Risk Factors Enrolled in PAT*

visiting supports parents to notice, identify, and practice interactions that help their children learn and grow in safe and interesting spaces. Home visitors work with families to screen and assess their child's progress. Families can share their observations and gather artwork, pictures, or video of their child learning. Together, the home visitor and parent use that information to plan home visits and socializations. Home visitors work with families to plan activities, interactions, and learning experiences with just the right amount of support to allow all children to participate, especially those with disabilities or suspected delays.

Demographic Characteristics: Approximately 70% of the families served have incomes below 100% of the Federal Poverty level. Fifty-three percent are white, 16% Black or African American, 14% other, 11% more than one race, 2% Asian, and 1% American Indian or Alaska Native. Seventy-three percent of families have a primary language of English and 23% have a primary language of Spanish.

Number of Families Served: In 2019, there were 374 children and pregnant individuals enrolled in home-based Early Head Start.

Geographic Areas Served: Home-based Early Head Start is only available in some areas of the state including Bristol, Burrillville, Central Falls, Coventry, Cranston, East Providence, Jamestown, Johnston, Middletown, Newport, North Providence, Portsmouth, Pawtucket, Smithfield, Tiverton, Warren, Warwick, and West Warwick. Home-based Early Head Start is not available in Woonsocket, Lincoln, and Cranston.

Number of Eligible Families Not Served: The estimate of target population for Early Head Start was calculated by counting the number of low-income children under age three. The capture rate in Woonsocket, Cranston, and Lincoln is significantly below the average for communities experiencing stress as well as the state rate overall. Most Early Head Start center-based programs typically have a long waitlist but waitlists vary for home-based services. Some communities, like Providence, have a greater demand for home-based services than others.

Early Head Start Capture Rate By Town

At Risk Community	Target Population: Estimated Number of Low-Income Children < age 3	Number Enrolled in Home-Based Early Head Start, 2019	Number Enrolled in Center-based Early Head Start, 2019	Capture Rate[17]
Woonsocket	1089	0	16	1%
Pawtucket	1417	33	31	5%
Providence	4231	164	32	5%
Central Falls	618	37	31	11%
West Warwick	404	13	26	10%
Newport	351	15	29	13%
Warwick	670	19	36	8%
Lincoln	192	0	3	2%
Cranston	888	0	22	2%
North Providence	360	16	10	7%
Washington County	1201	29	17	4%

[17] *Estimated % of Low-Income Infants and Toddlers Enrolled in Early Head Start*

At Risk Community	Target Population: Estimated Number of Low-Income Children < age 3	Number Enrolled in Home-Based Early Head Start, 2019	Number Enrolled in Center-based Early Head Start, 2019	Capture Rate[17]
Chariho (includes Charlestown, Richmond, and Hopkinton)	*113*	*5*	*2*	*6%*
Total – At-Risk Communities	**11,534**	**331**	**255**	**5%**
State Overall	**14,455**	**374**	**304**	**5%**

Source: RI KIDSCOUNT 2020 Factbook

Early Intervention (EI)

Early Intervention, Part C of the Individuals with Disabilities Education Act (IDEA), helps families support the growth and development of their infants and toddlers, birth through age three, who are delayed in their development or have a diagnosed condition known to cause developmental delay, including infants with Neonatal Abstinence Syndrome (NAS). Children are referred to EI for a comprehensive developmental evaluation to determine if they are eligible for services. Specifically, EI supports a child's participation within a family's daily routines and natural environments using coaching as the method of interaction between the family and the EI provider. There are nine EI grantees in the state that provide services statewide. In RI, EI is provided at no cost to families and is administered by EOHHS.
Home Visiting Model or Approach: Early Intervention
Services Provided: Depending on the child and family's needs, services may include: audiology or hearing, speech and language, occupational therapy, physical therapy, nutrition services, assistive technology, and other services as required by IDEA that address the needs that address the needs and priorities of the child's family.
Recipients of Services: Families with children under the age of three who meet the RI eligibility criteria for developmental delay in one or more areas of development, or a diagnosed condition known to cause developmental delays.
Targeted Goals/Outcomes*:* To identify, evaluate, and provide services for families to help them support their child's health and development.
Demographic Characteristics**:** Of the families who are determined eligible for EI, 40% enroll in EI when their child is between birth and age 1, 39% enroll when their child is between 1 and 2, and 21% enroll when their child is between 2 and 3. Eighty percent are enrolled due to a significant developmental delay and approximately 60% are covered by RiteCare, RI's Medicaid managed care program for families with children, pregnant individuals, and children under age 19. Fifty-six percent of enrolled children are white, 30% are Hispanic, 7% are Black/African American, 4% are more than 1 race, 2% are Asian, and <1% are American Indian or Alaska Native.
Number of Families Served: In 2019, there were 4,602 children eligible and enrolled in Early Intervention.
Geographic Area Served: Statewide
Number of Eligible Families Not Served: EI is a need-based service. All families with children who meet the eligibility criteria are able to enroll if they choose. Early Intervention in RI serves 6.1% of children from birth to age three. At-risk communities are likely to have higher need and therefore higher eligibility rates. RI typically ranks in the top 5 states for the percentage of young children served.

Early Intervention Number of Children Enrolled

At Risk Community	Number of Children < age 3	Number of Children Enrolled in Early Intervention	% of Children Under Age 3 Enrolled in Early Intervention
Woonsocket	1900	339	18%
Pawtucket	2959	384	13%
Providence	7609	1111	15%
Central Falls	1028	162	16%
West Warwick	1044	110	11%
Newport	820	80	10%
Warwick	2322	299	13%
Lincoln	587	91	16%
Cranston	2318	303	13%
North Providence	851	134	16%
Washington County	4489	513	11%
Charlestown	*186*	*25*	*13%*
Total – At-Risk Communities	**25,927**	**3,526**	**14%**
State Overall	**33,788**	**4,601**	**14%**

Source: RI KIDSCOUNT 2020 Factbook

Project Connect

Project Connect is a family preservation and support program working with DCYF to provide comprehensive wraparound support to strengthen families by helping parents to achieve a substance-free lifestyle. Project Connect staff are specially trained in substance abuse and child welfare risk assessment. The program is intensive, home-based, and provides services on average for one year.

Home Visiting Model or Approach: Comprehensive Wraparound

Services Provided: Services include counseling, substance use monitoring, home-based parenting education, parenting groups, and nursing services. Ongoing home visits by pediatric nurses are geared primarily toward monitoring the health and safety of children in the home and assisting parents with meeting their children's health care and development needs and overall family well-being.

Recipients of Services: DCYF-involved parents dealing with substance use disorder. Family risk may include domestic violence, child abuse and neglect, criminal involvement, poverty, inappropriate housing, poor employment skills, impaired parenting. Children may remain in the home or if needed, be removed to substitute care.

Targeted Goals /Outcomes: Keep children safe by reducing risk of child abuse/neglect in families where parental substance use disorder has been identified; enhance overall functioning of these families through the provision of services to address the safety of the home and monitor the child's hygiene and overall well-being; and reduce the need for out-of-home placement of children in families where substance use is a significant risk factor and expedite the permanency planning process for child who must be removed

Demographic Characteristics: In calendar year 2019, 78% (99) of families identified their race as white, 16% (20) identified as Black or African American, 2% (2) identified as Native American, 1% (1) identified as Asian, and 3% (4) declined to identify their race. Twenty-three percent (29) of families identified their

ethnicity as Hispanic, with 74% (93) identifying as Non-Hispanic, and 3% (4) declining to identify their ethnicity.
Number of Families Served: In 2019, 126 families participated in Project Connect. Capacity is 60 at any given time.
Geographic Area Served: Statewide

Project Connect Number of Families Enrolled

At Risk Community	Number of Families Enrolled in Project Connect, 2019
Woonsocket	13
Pawtucket	18
Providence	17
Central Falls	2
West Warwick	5
Newport	1
Warwick	11
Lincoln	0
Cranston	10
North Providence	5
Washington County	11
Charlestown	*1*
Communities at Risk-Total	**93**
Statewide TOTAL	**126**

Source: RI Department for Children, Youth, and Families

Family Care Community Partnerships (FCCP)

Family Care Community Partnerships (FCCP) is a program, managed by DCYF, designed to prevent child abuse and neglect and support the emotional, physical, and overall needs of families with children under age 18. Services are individualized for each family and include “high-fidelity wraparound services” and are provided in the home and other sites. There are five different RI agencies implementing FCCP statewide.
Home Visiting Model or Approach: High-fidelity wraparound services.
Services Provided: Regionally based care coordination, community-based single service referrals, and an array of community-based services and support delivered in the context of a wraparound. Care coordination takes place during home visits and through a wraparound process and referrals are made to community-based services and supports.
Recipients of Services: The following three populations of children and families are eligible to access the services and supports through the FCCP: 1) Families with children and youth who are at risk for child abuse, neglect and or dependency and DCYF involvement; 2) children birth to age 18 years old who meet the criteria for having a serious emotional disturbance; and 3) youth concluding a sentence to the RI Training School (RITS) who agree to participate, including youth leaving the RITS and youth leaving temporary community placement.
Targeted Goals/Outcomes: The primary goal has been to redesign service delivery by utilizing wraparound and natural supports to preserve families, enhance home and community-based intervention, prevent-out-of-home placement, and formal involvement with DCYF.

Demographic Characteristics: In calendar year 2019, the FCCPs served 2,833 families, of which 72% were from single caregiver households and 27% did not reside in permanent housing at time of intake. Thirteen percent of families require a translator for care. Twenty-four percent of children report being White Non-Hispanic, 23% Hispanic any race, 7% Black Non-Hispanic, 14% Other/Multiracial Non-Hispanic, and 33% with an unknown race/ethnicity. Children among the FCCP families served vary in age, with 28% under 5 years old, 23% between 5 and 9 years old, 31% between 10 and14 years old, and 18% between 15 and 18 years old.
Number of Families Served: In 2019, 2,833 families were referred to FCCP and 2,138 were enrolled.
Geographic Area Served: Statewide

FCCP Number of Referred Families Enrolled

Case address of FCCP Target Child*	Number Referred to the FCCPs, 2019	Number Enrolled in FCCPs, 2019	Capture Rate
Woonsocket	196	171	87%
Pawtucket	240	227	95%
Central Falls	122	116	95%
Providence	656	522	80%
West Warwick	97	74	76%
Newport	85	85	100%
Warwick	112	94	84%
Lincoln	22	18	82%
Cranston	99	84	85%
North Providence	33	26	79%
Washington County**	195	160	82%
Charlestown	*7*	*6*	*86%*
Communities at Risk- Total	**1,890**	**1,587**	**84%**
All other towns[#]	976	561	61%
Statewide TOTAL	**2,833**	**2,138**	**75%**

Source: RI Department for Children, Youth, and Families
**Categorized by address reported to FCCP. Does not indicate which FCCP region serves the child*
***Includes Charlestown, Exeter, Hopkinton, Narragansett, New Shoreham, North Kingstown, Richmond, South Kingstown, Westerly*
[#]*Those families experiencing homelessness with no reported address are included*

Positive Parenting Program (Triple P)

Positive Parenting Program (Triple P) is a program administered by DCYF that draws on social learning models of parent-child interaction that highlight the reciprocal and bi-directional nature of parent-child interactions. With clearly defined content, practice standards, and learning objectives, this program model is designed to teach positive strategies and parenting skills and their application to a range of target behaviors and settings. Triple P is a home-based service that is geared at working with multi-stressed caretakers of children, birth to age 12 and who exhibit behavioral or emotional difficulties, such as aggressive or oppositional behavior.
Home Visiting Model or Approach: Structured curriculum
Services Provided: Parenting Supports

Recipients of Services: Caretakers of children, (birth to age 12) who exhibit behavioral or emotional difficulties, such as aggressive or oppositional behavior.
Targeted Goals/Outcomes: The primary goal is to support positive parenting and reduce the risk of maltreatment and neglect.
Demographic Characteristics: Not available
Number of Families Served: From July 1, 2019 to June 30, 2020, 51 families participated in Triple P.
Geographic Area Served: Statewide

Positive Parenting Program (Triple P)

At Risk Community	Number Enrolled in Triple P July 1, 2019 to June 30, 2020
Woonsocket	8
Pawtucket	4
Providence	10
Central Falls	3
West Warwick	3
Newport	1
Warwick	1
Lincoln	1
Cranston	1
Washington County	6
Communities at Risk- Total	38
Statewide TOTAL	51

Source: RI Department for Children, Youth, and Families

Safe Care

Safe Care is a parent-training program administered by DCYF that supports parents/caretakers of children, birth to age five, with known risk factors for and/or a history of child neglect and abuse. The program is 20 to 22 weeks with home visits typically once per week. It includes structured curriculum sessions consisting of three modules: health, home safety, and parent-child/infant interactions plus an initial assessment and final re-assessment.
Home Visiting Model or Approach: Structured curriculum
Services Provided: Parenting Information and Coaching
Recipients of Services: Parents of children birth to age five, with known risk factors for and/or a history of child neglect and abuse.
Targeted Goals/Outcomes: The primary goal is to reduce the risk of abuse/neglect and support parents in building positive parent-infant/child interaction, home safety, and child health.
Demographic Characteristics: Not available
Number of Families Served: July 1, 2019 to June 30, 2020, 12 families participated in Safe Care.
Geographic Area Served: Statewide

At Risk Community	Number Enrolled in Safe Care from July 1, 2019 to June 30, 2020
Woonsocket	2

At Risk Community	Number Enrolled in Safe Care from July 1, 2019 to June 30, 2020
Pawtucket	2
Providence	3
Central Falls	
West Warwick	2
Newport	0
Warwick	0
Lincoln	0
Cranston	0
Washington County	1
Communities at Risk- Total	**10**
Statewide TOTAL	**12**

Source: RI Department for Children, Youth, and Families

Conclusions – Family Visiting Capacity

Statewide, across all programs, the potential eligible population is significantly greater than the number of families enrolled in programs. Among communities experiencing stress, the capture rate ranges from 5-76% depending on the program, with Healthy Families America having the highest capture rate.

Capture Rate By Program

	Statewide	***Communities At Risk***
First Connections	33%	38%
Nurse Family Partnership	21%	23%
Healthy Families America	68%	76%
Parents As Teachers	29%	27%
Early Head Start - Home-Based	5%	5%

When we look at overall capture rates by town compared to the average capture rate for communities at risk by program and town, we also see disparities in the capture rate for certain programs and towns. This analysis shows that the capture rate is below average for all MIECHV programs and Early Head Start in Woonsocket, below in four programs in West Warwick and Lincoln, an emerging at-risk community, and below in three programs in Newport, North Providence, and Cranston. Since First Connections is a primary feeder pipeline for long-term family visiting programs, lower rates of capture for First Connections in an area are likely to also impact capture rates for other programs. The table below summarizes this analysis.

At Risk Communities	Number of Risk Domains	First Connections	Nurse Family Partnership	Healthy Families America	Parents as Teachers	Early Head Start
Woonsocket	6	below	below	below	below	below
Pawtucket	6	on par	above	above	on par	on par
Providence	5	above	above	above	below	on par

At Risk Communities	Number of Risk Domains	First Connections	Nurse Family Partnership	Healthy Families America	Parents as Teachers	Early Head Start
Central Falls	4	above	above	above	above	above
West Warwick	3	below	below	below	below	above
Newport	3	below	below	below	on par	above
Warwick	2	above	below	below	above	above
Lincoln	2	below	below	above	below	below
Cranston	2	below	below	on par	above	below
North Providence	2	below	below	below	above	above
Washington County	2	below	below	on par	above	on par

*Data on capture rates for DCYF contracted services was not available.
**Early Intervention is not included in this analysis because it is a need-based service. All eligible children receive services.

Underserved Target Populations

An analysis of qualitative and quantitative data, indicates that there are several gaps in the delivery of early childhood family home visiting services including several populations that are significantly underserved. The section below describes these populations, many of which are populations of color. In addition, qualitative survey and focus group data indicate strong support for making family home visiting available to everyone. Universality would remove any stigma and promote health equity, because unaddressed disparities during the earliest years can lead to intensified health problems and widening social, educational, and economic gaps throughout the life course.

Underserved Populations - Communities of Color

Racial and ethnic disparities exist in RI across economic well-being, health, safety and education outcomes. Black and Hispanic children are more likely than White and Asian children to live in neighborhoods that lack the resources needed to support them to grow up healthy and successful. Additionally, other marginalized groups, such as the RI Southeast Asian community, experience significant disparities and resource deficits. At the time of the 2010 Census, nearly three-quarters (67%) of RI's children of color lived in one of the four core cities - areas with the highest percentage of children living in poverty. In 2010, more than three-quarters of the children in Providence (84%) and Central Falls (87%) were of minority racial and ethnic backgrounds. In addition, between 2014 and 2018, the Black infant mortality rate was 10.6 deaths per 1,000 live births in RI, which is over three times the White infant mortality rate of 3.3 deaths per 1,000 live births.[18] Also, 12.5% of American Indian and Alaskan Native infants, 11.1% of Black infants, 8.0% of Hispanic infants, and 7.5% of Asian infants were born at low birthweight, compared to 6.6% of White infants.[19]

Embedded within these persistent disparities are the ongoing effects of institutional racism—racism that began with the early days of RI's colonization and the subsequent reliance on Black slaves for both labor

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[18] *http://www.rikidscount.org/Portals/0/Uploads/Documents/Factbook%202020/Individual%20Indicators/infant-mortality-2020fb.pdf?ver=2020-04-03-103700-983*

[19] *http://www.rikidscount.org/Portals/0/Uploads/Documents/Factbook%202020/Individual%20Indicators/low-birthweight-infants-2020fb.pdf?ver=2020-04-03-103701-047*

and trade, through widespread displacement and asset-stripping through eminent domain via the Federal Housing Act, and the use of redlining to perpetuate racial segregation in the 20th Century. In addition, new immigrants to RI from Liberia, Nigeria, other African nations and the Caribbean may have different experiences than native-born African Americans, yet still be subject to similar prejudices and barriers that have held back the native-born population. Similarly, structural racism and inequity has impacted indigenous people present in RI. From 1635 to the present day, the Narragansett tribe has endured a variety of social injustices and interferences from colonists and the state. This includes but is not limited to “pressure to abandon the traditional ways and adopt Waumpeshau (white man) ideas of civilization”, slavery, slaughter, forced indebtedness, land seizures, a depletion of hunting and farming lands, discrimination and racism, and illegal state detribalization attempts.[16] To better engage and service communities of color, it is critical that the family visiting system in RI understand the history of systemic racism and work to dismantle policies and practices that continue to adversely affect maternal and child health outcomes. Our data identified several underserved communities of color as follows:

Womxn of color: 36.6% of family visiting programs report that they are not effectively engaging racially and ethnically diverse groups. In addition, the results of a maternal and child health survey conducted by SISTA FIRE using a participatory action research method, show that family visiting is not well-known among womxn of color and for those that know about the program, it is viewed with significant mistrust. Womxn of color associate family visitors with the state and see them as a state strategy for monitoring, policing, and separating families. This perception is born out of a long history of trauma resulting from racism and disproportionate levels of DCYF involvement in families of color. At the same time, 74% of survey respondents felt that supporting new moms in caring for their infant was critical.

Cape Verdean families*:* Nearly half of the 20,000 members of the Cape Verdean population in RI live in Central Falls and Pawtucket. It has been hard to engage Cape Verdeans in family visiting because of mistrust of outsiders and lack of family visitors that speak Portuguese and share their cultural background. There are also many undocumented Cape Verdeans in the population who are afraid to engage because they feel it may have adverse effects on their status in RI.

Families that Speak English as a Second Language**:** Focus group participants reported that it is very difficult to engage a family when the family visitor and the family speak different primary languages because it is challenging for families to fully understand a program unless it is presented in their primary language. While interpreters can help, it is difficult to establish trust and relationships when there is a translator facilitating the exchange. In addition, visits take longer to prepare and deliver when an interpreter is involved, which can be a barrier to participation, especially for families with inflexible schedules. Families are most likely to engage when the family visitor shares their linguistic and cultural background.

Southeast Asian Population (SEA): RI is home to about 17,000 SEAs, including individuals who identify as Burmese, Cambodian, Filipino, Hmong, Laotian, Thai, and Vietnamese. SEAs make up about half of the Asian population in RI and 1.6% of the total population. Programs report that they are underserving the Southeast Asian populations in their catchment areas. While this is a priority population, they have struggled to engage families because of communication barriers due to linguistic and cultural differences and mistrust. The impact of cultural and linguistic gaps between the family and the visitor cannot be underestimated. Parenting is inextricably tied to culture and it is difficult to build trust without a sensitivity or inherent familiarity to the Southeast Asian parenting culture. Some programs have successfully engaged Southeast Asians by partnering with the Center for Southeast Asians to use culturally responsive strategies

to recruit and engage families. Up until recently the Center for Southeast Asians had two locations: Providence and Woonsocket. The Woonsocket location has closed.

Undocumented immigrants*:* In today's climate, undocumented immigrants are living with a sense of great fear and uncertainty and are hard to engage in family visiting. Many are not comfortable sharing information with the family visitor and worry that involvement in programs like family visiting will get them deported.

Narragansett tribal community (Washington County): Programs in Washington County have been unable to establish trust and maintain contact with Narragansett tribe leaders.

Additional Underserved Populations

In addition, our data identified two additional underserved populations:

Adolescent parents*:* 48.3% of programs said they were underserving adolescent parents. Program staff report challenges in recruiting and retaining adolescent parents. To receive assistance from family visiting, teens have to navigate the parenting demands of caring for a newborn that can make it difficult to take time out of school or work for visits. They may also be discouraged from seeking services by their partners or families, especially if the services are perceived to conflict with parenting or other responsibilities.

Families Without Access to Technology: While the opportunity to engage in family visiting virtually has allowed many families to increase their engagement because of increased flexibility, for many, the need for virtual visits has been a barrier to service and has decreased or prevented their participation. There are many families that do not have access to devices that support video conferencing or they are sharing one device between multiple household members. In addition, many households do not have access to Wi-Fi to allow them to connect through video conferencing.

Extent to Which Home Visiting Services Meet the Needs of Families

The section below addresses key themes that emerged from the data regarding families' experience with family visiting, the cultural responsiveness of family visitors, the extent to which families perceive needing other services, and barriers to services.

Families' Experience with Family Visiting

Most families feel comfortable with their family visitor*:* Seventy-four percent of the 54 respondents to the community survey who had experience with family visiting said that they felt comfortable with their family visitor and 72% said that they provided them with useful information. Sixty-eight percent of respondents said that their family visitor spoke the same language and 62% said their family visitor shared their values. Fifty-five percent said that their family visitor provided them with emotional support. 23% said that their family visitor provides them with day-to-day help. Specific suggestions for improvement from respondents included increasing the frequency and time spent during visits. Additional suggestions included improving care coordination across programs, providing better information on available resources, and offering more wrap-around services for the whole family.

Virtual visits have had a mixed impact on family engagement across programs: While engagement in MIECHV-funded programs increased during the pandemic (visit frequency increased during the second

quarter 2020), Early Head Start and Early Intervention have experienced decreased enrollment statewide. Prior to COVID, Early Intervention was increasing its enrollment by about 7-10% per year.

Cultural Responsiveness of Family Visiting

Families need and want a cultural connection with their family visitor (and one that speaks their language): Parenting is inextricably tied to culture and it is difficult to build trust without sensitivity to or inherent familiarity with the family's parenting culture. Both qualitative and quantitative data show that families want to work with family visitors that understand their culture and speak the same language and are more likely to engage when there is a strong cultural and linguistic fit.

Rhode Island needs more interpreters: When an interpreter is necessary, it is important to be able to quickly access interpreters that speak the needed language. Currently, there are not enough interpreters, especially those that speak American Sign Language (ASL) and African languages. In addition, there can be long wait times to access an interpreter increasing the likelihood that the family will disengage.

Extent to Which Families Perceive Needing Other Services

Gaps in the availability of behavioral health clinicians, especially those trained in trauma and postpartum depression: There are not enough behavioral health providers in many areas of RI including, but not limited to: Woonsocket, Lincoln, Washington County, Newport, West Warwick. While the Moms PRN helpline[20] has helped family visitors make referrals to clinicians, there are still very few behavioral health providers available, especially those who are bi-lingual and/or trained in trauma and/or postpartum depression. In addition to a lack of adequate numbers of providers there are several obstacles to accessing services including transportation, inadequate insurance coverage, and language barriers.

There is not enough access to safe and affordable housing: RI does not have enough stable, affordable, and safe housing especially in Woonsocket, Providence, Central Falls, Pawtucket, Cranston, Lincoln, Providence, West Warwick, and Washington County. Housing instability and shelter use are often related to increased family stress and school instability. Connecting families to stable, affordable, family-friendly housing can reduce parental stress and negative side effects for children.

Families would like more flexible options: Both recipients of family visiting services and family visiting frontline staff reported that families would like more flexible ways to access family visiting. For example, they would like ways to test the "fit" of their family visitor before committing to the service long-term as well as peer group options where they can be social with other families. In addition, families that are able to participate in family visiting virtually appreciate the ability to have visits on the weekends or during the evenings and would like flexible scheduling options to continue after face-to-face visits resume.

Barriers to Services

***Stigma*:** Many survey and focus group participants reported that stigma is one of the largest barriers to family engagement. To address this, stakeholders recommend making family home visiting available to everyone. Universal access to family visiting would remove any stigma and promote health equity,

[20] *A free hotline for medical providers and frontline staff. Users can ask general questions about perinatal mental health or substance use, or specific questions pertaining to a particular patient.*

because unaddressed disparities during the earliest years can lead to intensified health problems and widening social, educational, and economic gaps.

Not enough access to critical social supports: Social determinants of health such as access to economic and educational opportunities, transportation, and quality childcare are inexorably linked to families' abilities to thrive. Families know this and are seeking wraparound services to address the needs of the whole family, not just their child. While family visitors play an important role in helping families connect to these critical supports, they cannot help the family if these social supports are not available.

In addition, the COVID pandemic has highlighted the inequities and injustices that threaten the well-being, safety, and lives of RI families living on the margins. There are increasing rates of hardship especially with employment, income, and food sufficiency. All of these hardships affect family well-being and stability and it is critical that the State of RI move quickly to close gaps in basic needs.

The hardest and most important supports to access include:

- ***Transportation:*** This is a significant barrier to access for many areas of RI including West Warwick, Woonsocket, Central Falls, Pawtucket, Providence, and Washington County
- ***Childcare:*** Access to flexible affordable childcare, especially for children under age three and families working third or evening shifts, is an issue statewide. The COVD pandemic has significantly exacerbated this problem.

Families need better access to technology: While many families have been able to engage with family visitors virtually, there are a significant number who do not have devices with video conference capability and/or Wifi connectivity. For example, the West Elmwood Health Equity Zone reported that 38% of families residing in the Olneyville neighborhood did not have access to Wifi. To ensure equitable virtual access to family visiting, families will need consistent and reliable access to technology and Wifi.

Gaps in Staffing, Community Resource, and Other Requirements for Delivering Evidence-Based Family Visiting Services

The section below addresses key themes that emerged from the data regarding staffing capacity, professional development, partnerships, funding, and recruitment.

Awareness of family visiting is low, especially among womxn of color: Only 16% of the 422 respondents to the community survey, who did not have prior experience with family visiting, said that they were aware of family visiting. SISTA FIRE survey results reinforce these findings showing that awareness levels of family visiting programs among womxn of color are low. Both community members and professionals said that more outreach and information was needed to raise awareness of the programs.

In contrast, awareness of Early Intervention was a little higher. 37% of respondents to the community survey who did not have prior experience with family visiting said that they were aware of Early Intervention. The program most well-known among womxn of color was Head Start (77% of respondents knew about it).

Need to expand referrals and increase brand recognition: Respondents to the professional survey and frontline staff focus group participants reported that there are not enough referrals coming from

obstetricians and gynecologists and they would like to see more referrals coming from pediatricians as well.

Perception among womxn of color that family visitors are connected with the DCYF: Many families of color view family visitors as state DCYF workers or believe that they are likely to report them to state authorities. This perception is born out of a long history of trauma resulting from racism and disproportionate levels of DCYF involvement in families of color and it deters womxn from participating in family visiting.

Need more staff with the same cultural and linguistic backgrounds as the families they serve: Only 42% of community survey respondents who had used family visiting services said that their family visitor shared a similar cultural background as their families. Similarly, 68.5% of family visiting agency survey respondents said that they do not have enough staff that share the cultural background as their participating families, and this is a barrier to implementing their programs. In addition, 84% of agencies reported that they do not have enough staff that speak the same language as their participating families; this is a barrier to implementing their programs.

Agencies find it hard to hire staff with required credentials and experience: 51% of family visiting agency survey respondents said that not having enough qualified staff was a barrier to implementing their programs. In addition, 48% said that it was hard to hire family visitors with relevant experience and 43% said that it was hard to hire family visitors with the required credentials.

Staff turnover is a significant challenge: Staff turnover contributes to participant dropout rates and is a significant challenge for all family visiting programs. One of the biggest reasons for staff turnover is low wages. The Department of Human Services (DHS) conducted a workforce study in partnership with the RI Department of Education (RIDE), RIDOH, DCYF and EOHHS and learned that 60% of Directors believed that insufficient compensation was a reason for family visiting staff turnover. And the same study showed that 70% of family visiting staff would leave their job if their salary does not improve. Agencies and family visitor's express frustration that the pay rates do not reflect the complexity and difficulty of their job. They note the challenge of caring for families while they themselves are not earning a living wage and are struggling with many of the same basic needs that their families are trying to meet. Greater efforts are needed to ensure family visitors can earn a living wage.

Need for increased collaboration between family visiting, health and behavioral health care providers, substance use treatment providers, and schools: Families and frontline staff cite a need for increased collaboration between family visiting and other providers to help facilitate warm hand-offs, align and reinforce key messages and communication with the family, coordinate services, and eliminate duplication. This is particularly important for families with complex needs who are involved with multiple programs and providers. The agencies cited lack of time, limited staffing, and limited funding as the primary barriers to increased collaboration.

Stagnant funding levels and reimbursement rates make it difficult to cover the cost of family visiting and appropriately compensate family visiting professionals: Funding levels, and reimbursement rates have not kept up with the rising costs of providing family visiting, making it harder to find agencies to provide the programs and difficult for agencies to offer wages that support staff retention.

Specifically, Medicaid reimbursement rates for First Connections have not increased in decades and are not sufficient to cover the total cost to the agency for a visit, making it increasingly hard to find agencies to run the program.

Nurse-Family Partnership (NFP) receives formula funding for 175 slots from HRSA and additional funds from DHS for 25 slots. Currently, no state general revenue funds are allocated for NFP. The cost per family is approximately $6,000/year. For many years the target cost was trending down as agencies achieved economies of scale. It has now leveled off and is starting to outpace the level of reimbursement available.

Healthy Families America (HFA) is completely funded by MIECHV funds with a cost of $4800/year per family. Currently, no state general revenue funds are allocated for HFA. Similar to NFP, the costs have leveled off and are starting to outpace the level of reimbursement available.

Finally, federal funding from HRSA funds 350 Parents as Teacher (PAT) slots and RI's competitive Preschool Development Grant funds another 300 slots. The cost per family is $3,600. Currently, no state general revenue funds are allocated for PAT. The per family funding levels for PAT relative to the cost of providing the program are slightly more robust than funding for other long-term programs but still not enough to appropriately compensate family visitors.

RI will need to secure more competitive funding or additional state dollars to continue to provide long-term family visiting programs. Currently, RI is one of the few states that does not contribute state dollars to the cost of the program.

In addition, it will be important to increase Medicaid reimbursement rates and billable activities for First Connections so that this important program can continue to identify at risk families and help enroll them in needed services, including long-term visiting.

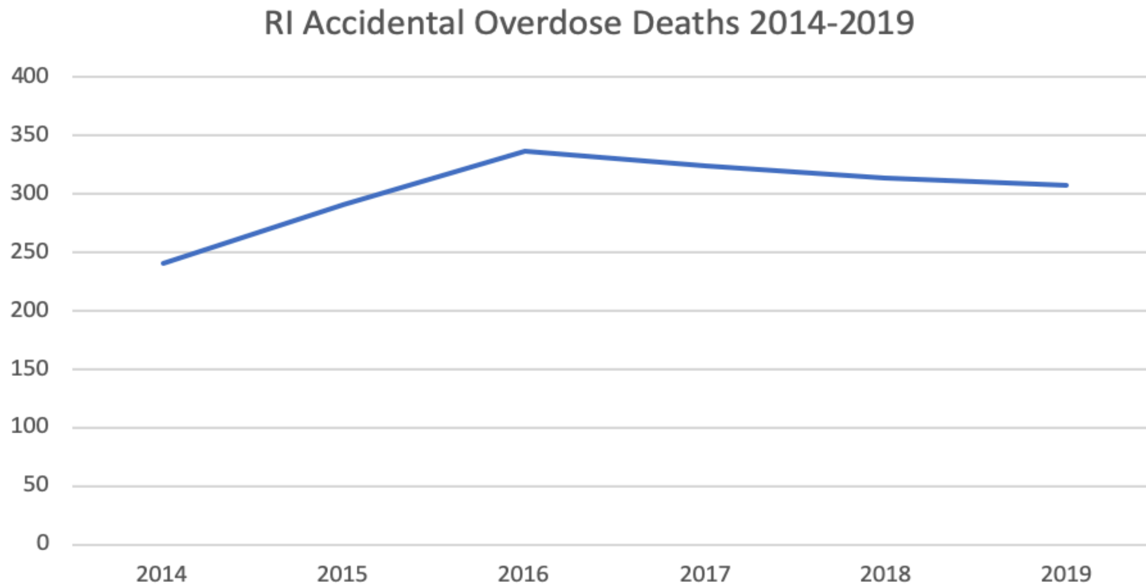
Rhode Island: Capacity for Providing Substance Use Disorder Treatment and Counseling Services

This section describes RI's current capacity for providing substance use disorder treatment and counseling services for pregnant individuals and families with young children, who may be eligible for MIECHV services. This assessment draws on various qualitative and quantitative data sources including:

- Focus groups of pediatricians, biological families, frontline community-based staff, nurses, and foster families
- Medicaid claims data (February 2017 - February 2019)
- RI hospital admissions and discharge data (January 2016 - December 2019)
- RI overdose death data (January 2014 - December 2019)
- Interviews with state agency leaders
- Provider information from BHDDH and SAMHSA

Current State: Prevalence of Substance Use Disorders (SUD) Among Pregnant and Parenting Individuals and Their Children

Although RI is making great strides in serving individuals with substance use disorders (SUD) and opioid disorder (OUD), the state continues to experience a serious opioid and substance use crisis that BHDDH, RIDOH, DCYF, law enforcement, the court system and other stakeholders are working to address.



Overdose deaths had been declining since 2016, but during the COVID-19 pandemic, the number of overdose deaths has been increasing and trending to exceed 2018 (314) and 2019 (308) numbers[21]. We suspect that this increase is primarily due to the pandemic. The PreventOverdoseRI Taskforce is mobilizing resources and strategies to try to reverse this alarming trend.

Substance Use Among Pregnant and Postpartum Individuals

In 2019, there were 10,718 pregnancy admissions of RI residents and 4.89% (522) of those individuals had a substance use disorder diagnosis[22]; slightly lower than the 2016 rate of 5.91%. Individuals 15-24 years of age had pregnancy admission with substance use disorder at slightly higher rates compared to people age 25 and up. Sixty-seven percent of pregnancy admissions for substance use disorder are white. Seventy five percent of admissions are covered by Medicaid and 14% are covered by private insurance. One hundred percent of pregnancy admissions with SUD have a co-occurring mental illness.

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[21] *https://health.ri.gov/data/drugoverdoses/*

[22] *SUD diagnoses include disorders involving: opioids, alcohol, tobacco, or other substances.*

Pregnancy admissions with substance use disorder (SUD) - RI resident only

	2016		2017		2018		2019	
	Total Births	**% with SUD Admissions**	**Total Births**	**% with SUD Admissions**	**Total Births**	**% with SUD Admissions**	**Total Births**	**% with SUD Admissions**
15-24	2,540	6.22%	2,410	6.10%	2,187	6.26%	2088	5.94%
25-34	6,725	6.16%	6,603	5.18%	6,568	5.33%	6342	4.64%
35+	2,149	4.79%	2,184	3.98%	2,311	3.85%	2288	4.55%
Total	**11,414**	**5.91%**	**11,197**	**5.14%**	**11,066**	**5.21%**	**10718**	**4.87%**

Source: RIDOH Hospital Discharge Data 2016-2019

The majority of pregnancy admissions with SUD are related to nicotine dependency followed by cannabis and opioids. The number of admissions related to nicotine and opioid dependency have been declining - opioid related admissions which have declined by 31% since 2016 and nicotine related admissions have declined 36% since 2016. In contrast, cannabis related pregnancy admissions have increased across all age, race, and ethnic groups, especially among white individuals between the ages of 25-34.

Number and Percent of Total Pregnancy Admissions with Substance Use Diagnosis By Substance Category

	2016		2017		2018		2019		
Substance	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**Total % Change**
Alcohol Related Admission	13	2%	13	2%	22	4%	12	2%	*
Opioid Related Admission	155	21%	148	24%	133	21%	107	19%	-31%
Cannabis Related Admission	62	8%	58	9%	66	11%	98	18%	58%
Cocaine Related Admission	10	1%	12	2%	13	2%	16	3%	*
Stimulant Related Admission	<5*	*	<5*	*	<5*	*	<5*	*	*
Nicotine Dependant Related Admission	499	67%	387	62%	386	62%	321	52%	-36%
Other	<5*	*	<5*	*	<5*	*	<5*	*	*
Total Admissions	**743**		**622**		**576**		**558**		-25%

Source: RIDOH Hospital Discharge Data 2016-2019
** Data are statistically unreliable and rates or percentages should not be calculated.*
NR = not reported[23]

Substance Use Among Pregnant and Postpartum Individuals Enrolled in Medicaid

Among pregnant and postpartum individuals enrolled in RI Medicaid, the diagnosed with substance use disorder is nearly double the overall state rate and has stayed between 11-12% over the past three years. Of those with a SUD diagnosis approximately 20% receive treatment[24]. Despite higher rates of substance use among pregnant and postpartum individuals ages 15-25, the percent of people in this age range receiving treatment is lower than people 25 or older.

[23] *For Internal Use Only*
[24] *Pregnant women with a SUD treatment procedure code, or who received methadone or buprenorphine.*

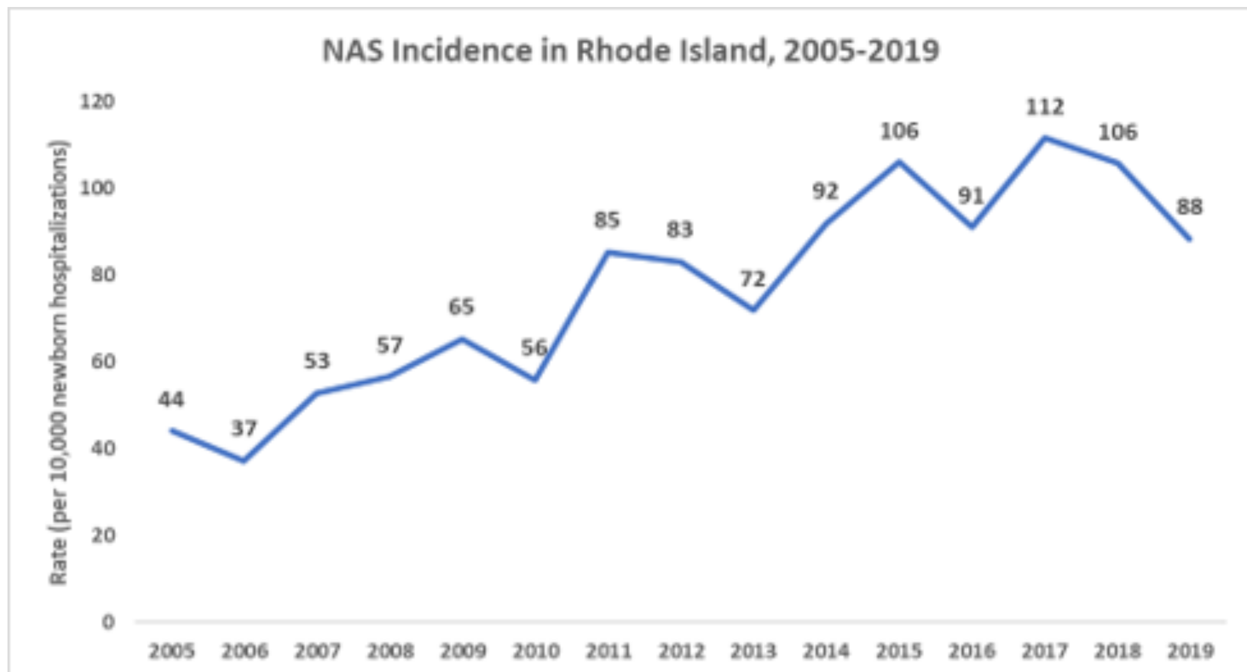
Pregnant and postpartum individuals in RI Medicaid with a SUD diagnosis who received treatment

Age (Years)	2/2/2017 - 2/1/2018	2/2/2018 - 2/1/2019	2/2/2019 - 2/1/2020
15-25	13.3%	10.4%	*
25-35	25.4%	22.4%	20.8%
35+	22.9%	20.4%	20.3%

RI Executive Office of Health and Human Services, SUD and Pregnant Individuals Subpopulation, February 2017 through February 2020
** Data are statistically unreliable and rates or percentages should not be calculated.*

The number of pregnant individuals on Medicaid and diagnosed with OUD has stayed constant over the three years, at about 2.6% of the total population of pregnant individuals. Among pregnant individuals, those 25 and older have the highest rates of OUD. The hospitalization rate of pregnant individuals with a primary to tertiary OUD diagnosis has decreased from 1.1% to 0.6% over the three-year period.

Neonatal Abstinence Syndrome (NAS) and Substance Exposed Newborns (SEN)
The NAS rate has been decreasing since 2017.[25] From February 2019 through February 2020, Medicaid claims data show that approximately 3.1% of newborns born in RI were prenatally exposed to substances, down from 3.9% in 2017-2018. We refer to these infants as Substance Exposed Newborns (SEN). Approximately 3% of the SEN cohort had an NAS diagnosis. Looking at the NAS cohort, approximately 75% of the infants' mothers were white and on Medicaid, and 60% were engaged in Medication Assisted Treatment (MAT).



Note: Rate = Number of infants born in RI to RI-resident individuals with NAS (ICD-9 code 779.5 or ICD-10 code P96.1) per 10,000 newborn hospitalizations. Source: Hospital Discharge Data, RIDOH

[25] *It is worth noting that in 2019, the birth rate in RI dipped slightly.*

Substance Use and DCYF Involvement

Approximately half of the families who have infants experiencing NAS are involved with DCYF at hospital discharge. 70% of NAS infants are discharged home with their biological parent(s) and 30% are placed in foster care.[26]

As a matter of policy, DCYF is unable to open an investigation when the subject of a hotline call is reporting suspected abuse or neglect of an unborn child. In such a case, DCYF Child Protective Services (CPS) issues a "hospital alert" in the form of a letter to all in-state birthing hospitals, which notifies them of the hotline call and instructs them to contact DCYF if the woman in question delivers at that hospital. If the hospital alert details substance use, DCYF's Substance Use Liaison is notified and attempts to make contact with the pregnant individuals before delivery to offer support including treatment and recovery options. If the woman accepts, case conferencing is initiated to ensure coordinated care takes place. In the face of substance use disorder, every effort is made by DCYF to keep the mother-child dyad intact. If substance use is a significant risk factor to the infant's day-to-day safety, the child may be placed into relative or non-relative foster care. DCYF also contracts for several specialized family visiting programs for families that are involved with the department such as Project Connect, which provides home-based services for high-risk families affected by parental substance use disorders and involved in the child welfare system. The program supports children ages 0-17, their families, and pregnant and parenting youth. The Project Connect staff is specially-trained in substance use disorders and child welfare risk assessments.

Continuum of Care, and Prevention, Intervention, and Recovery Support

RI has a comprehensive array of SUD treatment services across the full continuum of care including outpatient services, intensive outpatient service (IOP), medication assisted treatment (MAT), intensive levels of care in residential and inpatient settings, and medically supervised detoxification services. In addition, the state also focuses on prevention, intervention, and recovery support; services associated with these categories include community education and awareness, needle exchange, screening, 24/7 SUD/MH crisis resource phone line and walk-in triage center, pregnant and parenting Peer Recovery Specialists, family visiting, and non-Medicaid, grant-funded Recovery Centers and Recovery Housing.

Treatment Continuum of Care

The following section describes the current state of treatment in all of these areas. The table below provides a summary of total capacity, specialized programs for pregnant and parenting individuals, and gaps in services. These are further described after the table.

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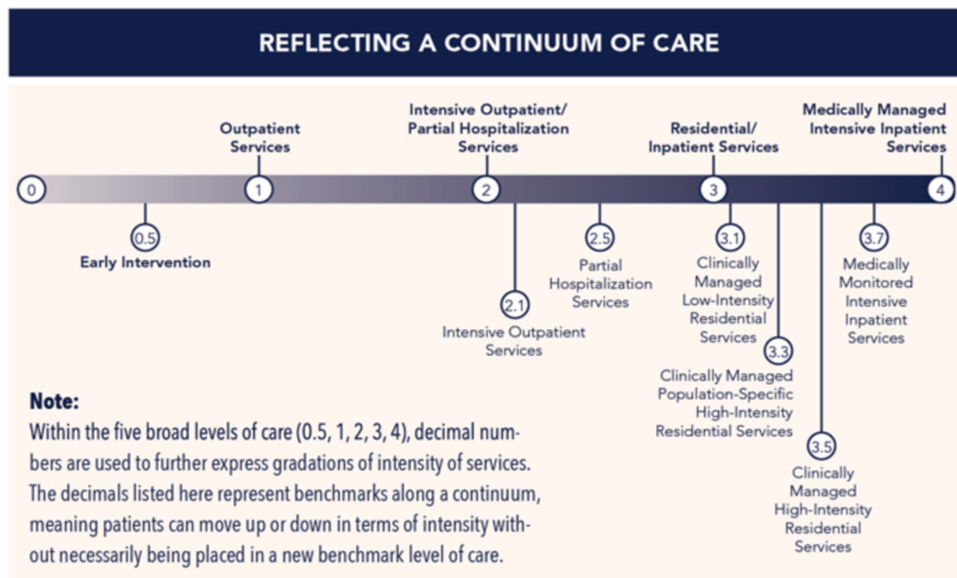
[26] *RI Department of Health. July 2018 thorough April 2020*



Early Intervention (0.5)

Early intervention services are designed for adults or adolescents who are at risk of developing a substance use disorder but do not display any diagnostic criteria to be admitted to rehab. (Note: This is not the same as Early Intervention, the term used to describe the services and supports that are available to babies and young children with developmental delays and disabilities and their families.) During early intervention, treatment focuses on the risk factors that predispose the person to substance use and educates the individual about the negative repercussions of substance misuse. The duration of early intervention services greatly depends on the patient's understanding of the perils of substance use and whether he or she makes behavioral changes to avoid the path to substance misuse. Patients are closely monitored for symptoms that indicate they need a higher level of treatment. RI has a prevention infrastructure with strategies for the general population, targeted subgroups, and individuals who are experiencing early signs of substance abuse including, but not limited to:

- Brochures, Media Campaigns, Public Service Announcements
- Classroom Education and Parenting Classes
- Drug Free Events, Youth and Adult Leadership Opportunities
- Problem Identification: Early identification and Referral (focus is on high school students)

While RI's current early intervention efforts are not specifically focused on pregnant and postpartum individuals, this population is a subset of most of the targeted groups. However, more could be done to specifically reach people prior to pregnancy and educate them about the dangers of substance use during pregnancy.

Summary of Treatment Capacity

Level	Total Capacity	Specialized Program for Pregnant or Parenting Individuals	Assessment of Gap
Early Intervention (0.5)	Not applicable	None	Additional focus on pregnant and postpartum individuals needed.
Outpatient Treatment (1.0)	25 providers	1 providers (Project Link)	Shortage of behavioral health providers that take insurance, especially in rural areas including Block Island.
Outpatient MAT	635 practitioners	1 provider (MOMs Matter)	Need more than 1 comprehensive care model that includes parent and baby health care and MAT, especially with the transportation challenges that exist in Rhode Island.
Intensive Outpatient (2.0)	18 providers	5 providers	Sufficient
Partial Hospitalization Services (2.0)	4 providers	2 providers	Sufficient
Residential Services (3.0 -3.5)	9 providers	3 for women 1 for pregnant and postpartum individuals and their children	Need additional beds in facilities that are licensed to treat both pregnant and postpartum individuals and their children. Need a residential facility that will serve individuals with children who are not immediately postpartum.
Medically Monitored Intensive Inpatient Services (3.7)	3 providers	None	Insufficient
Medically Managed Intensive Inpatient Services (4.0)	1 provider	None	Insufficient

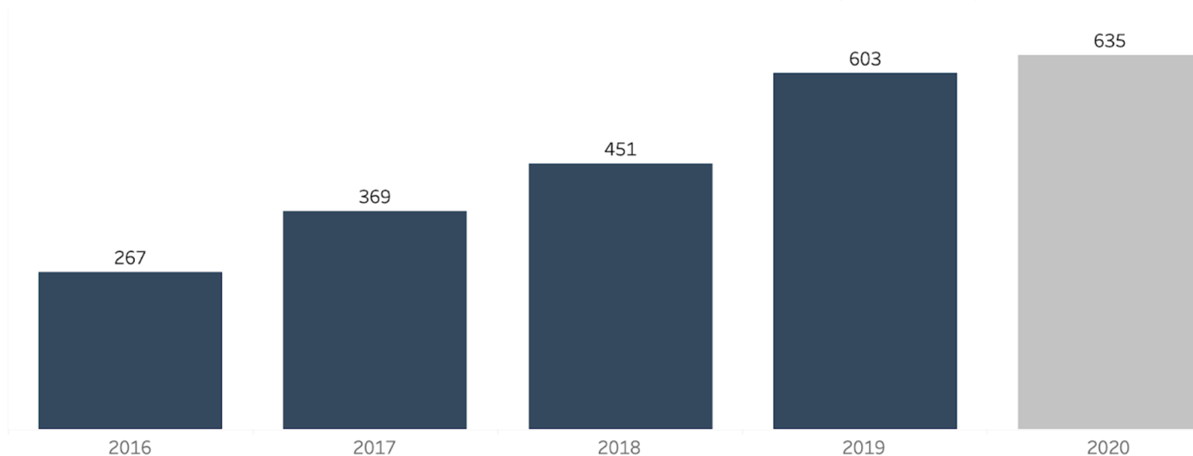
Outpatient Treatment (1.0)

General outpatient treatment services include both basic and intensive services such as outpatient medication-assisted treatment (MAT), detoxification and general substance use disorder counseling.

According to BHDDH, there are 25 licensed practices that provide basic outpatient treatment for substance use in RI.[27] The programs are concentrated in the more population dense areas of RI.

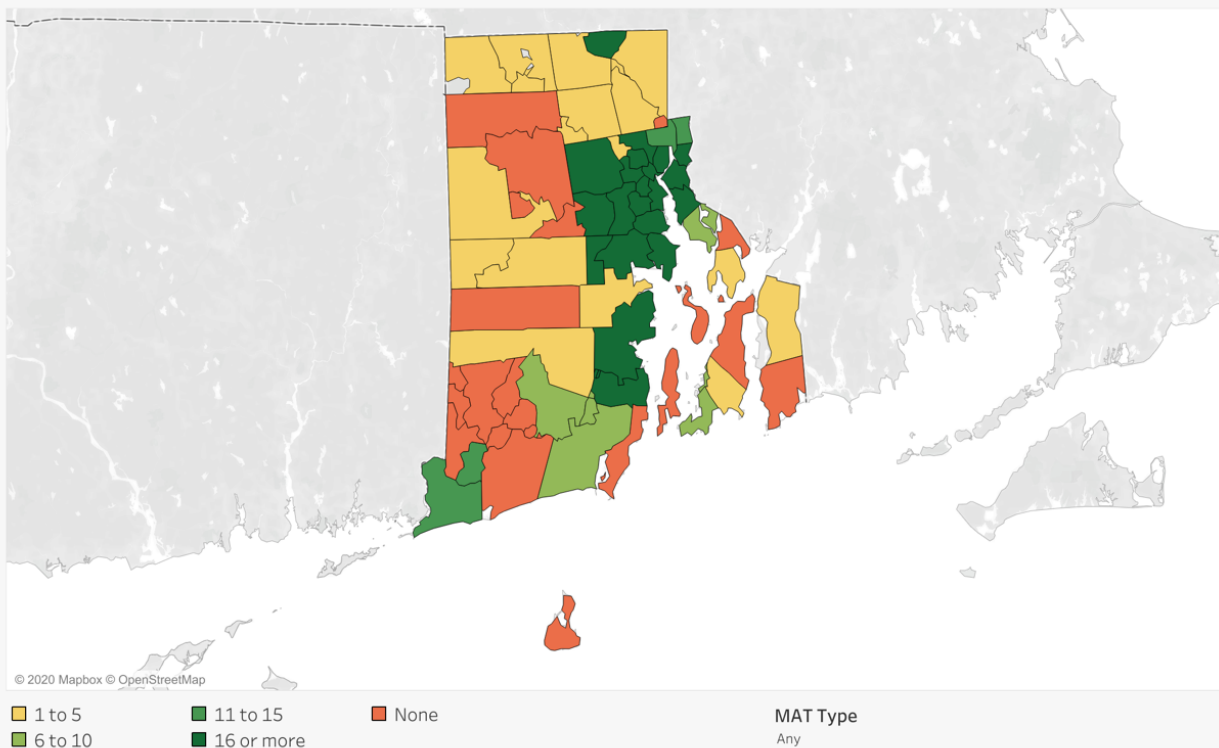
Project LINK: Women & Infants Hospital and The Providence Center both offer Project LINK which provides specialized substance use and mental health outpatient treatment for pregnant individuals and parents with young children. Intensive outpatient and non-intensive outpatient services help improve the health and well-being of new mothers. Services include individual and group therapy, case management, and parenting and self-care education. On-site child care is also available to remove barriers to treatment.

Outpatient Medication Assisted Treatment (MAT): RI is a leader in the provision of (MAT): Medicaid fully covers MAT, there is no MAT waiting list; and providers have capacity to provide treatment. In fact, through an initiative of the Governor's Overdose Prevention and Intervention Task Force, RI has increased the number of people accessing evidence-based medication-assisted treatments (MAT) for opioid addiction (Buprenorphine, Methadone, and VIVITROL) and significantly increased the number of trained and DATA-waived practitioners who are able to prescribe MAT from 267 in 2016 to 635 in 2020.



https://preventoverdoseri.org/medication-assisted-therapy/

[27] *The SAMHSA treatment locator also lists 25 general outpatient practices but there are differences between the two lists. For example, SAMHSA lists 4 practices that are not included in the BHDDH directory. There are also 6 practices listed on the BHDDH directory that are not included in the SAMHSA directory.*



https://preventoverdoseri.org/medication-assisted-therapy/

MOMSMatter: The MomsMATTER program at Women & Infants Hospital provides integrated, comprehensive services for pregnant and postpartum individuals with SUD and infants with NAS. Patients can be referred by their obstetric provider during pregnancy or the postpartum period. Services include:

- Medication assisted treatment with buprenorphine for opioid use disorder
- Assistance in caring for infants with neonatal abstinence syndrome (NAS) in collaboration with pediatricians at Women & Infants Hospital
- Treatment of acute withdrawal as an inpatient at Women & Infants Hospital
- Inpatient pain management for opioid-dependency at Women & Infants Hospital

Intensive Outpatient/Partial Hospitalization Services (2.0)

An **Intensive Outpatient Program** (IOP) for substance use disorders provides a more structured treatment program on a part-time basis. Treatment includes individual and group therapy, medication management, 12-step groups, peer support, family therapy, toxicology screening, and medical management. There are 18 IOP programs located in RI and five that have specialized programs for women.

A **partial hospitalization program** (PHP) is one in which a patient stays in the **hospital** 20 hours a week, usually during the day. Patients do not stay overnight. A PHP provides a mix of outpatient individual and group counseling in a setting with medical **services**. There are four partial hospitalization treatment

programs in RI (The Providence Center, AdCare, Phoenix House and Community Care Alliance). Two of these programs (The Providence Center and Phoenix House) have a specialized program for pregnant and postpartum individuals.

Residential Services (3.0-3.5)

Residential services facilitate the application of recovery skills, relapse prevention, and emotional coping strategies. They provide services that are described as co-occurring capable, co-occurring enhanced, and complexity capable services, which are staffed by designated addiction treatment, mental health, and general medical personnel who provide a range of services in a 24-hour treatment setting. There are nine residential substance use treatment facilities in RI. Three licensed providers operate facilities - Phoenix House, Providence Center, and Gateway - are specifically for women, including pregnant individuals. SSTARBirth is specifically for pregnant, postpartum, and parenting individuals. SSTARBirth, which has 14 beds, is the only residential program licensed by DCYF allowing them to serve post-partum individuals and their children together. Currently, RI does not have a residential facility that will serve individuals with children who are not immediately postpartum.

In RI, all pregnant residents seeking SUD residential treatment receive priority status for admissions and generally, there is very little wait for services (no more than 48 hours). If immediate placement is not available, people can receive assistance in finding either interim services or the first available opening at another SUD treatment program. However, postpartum and parenting individuals often face waiting periods for services due to the limited bed capacity. This has been identified as a treatment gap. Additionally, as post-partum individuals are at high risk for suicide ideation, depression, and relapse 9-18 months postpartum, postpartum and parenting individuals should be prioritized for services up to 18 months postpartum.

Pregnant or parenting individuals without insurance can be enrolled in Medicaid, if they meet the eligibility requirements, or covered with Substance Abuse Prevention and Treatment Block Grant (SABG) funds.

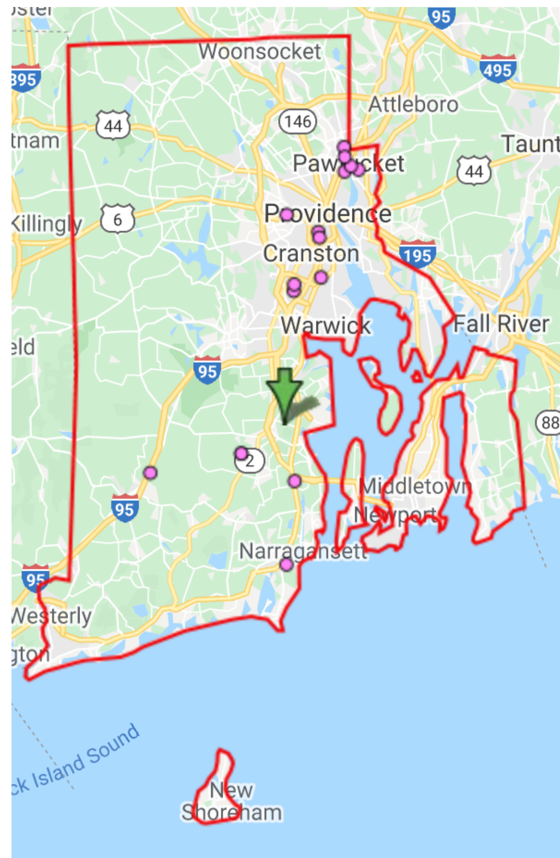


Figure: Residential services facilities in Rhode Island as of 8.25.20 (SAMSHA)

Medically Monitored Inpatient Services (3.7)

Medically monitored facilities (3.7) provide 24-hour nursing care with a physician's availability in a community setting. These programs have the ability to provide coordination of necessary services, or other levels of care are available through direct affiliation or referral processes (such as step-down services for continuing care and/or medical follow-up. Phoenix House, AdCare, and Butler Hospital are licensed to provide this level of care. Between them there are a total of 79 beds. However, RI does not currently have a medically monitored facility for pregnant and postpartum individuals with acute mental or physical health needs that are not severe enough for medically managed inpatient services but too acute for residential services.

Medically Managed/Monitored Intensive Inpatient Services (4.0)

Medically managed treatment is provided in a hospital inpatient setting (4.0) and is typically directed toward medically complex individuals who are detoxing. Roger Williams Medical Center is the only facility that provides 4.0 level services. There are 15 beds, and currently, there is no availability. In addition, they do not admit pregnant individuals for detox because they do not have OB services. Pregnant individuals who require detox are referred to Rhode Island Hospital or Women and Infants Hospital and there are times when bed availability for pregnant individuals to detox is been insufficient.

Other

NAS Deliveries

Of the five birthing hospitals in RI, 81% of Rhode Island-born NAS infants are delivered at Women & Infants Hospital. Those who receive inpatient treatment stay on the Family Care Unit. Kent Hospital and Newport Hospital also have the clinical capacity to treat NAS infants. NAS infants born at Landmark Medical Center and South County Hospital, and in need of treatment are usually transferred to Women & Infants, Kent, or Newport Hospitals.

Plan of Safe Care (POSC)

RI has developed a Plan of Safe Care (POSC) process to support all infants born affected by substance exposure, withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder. The purpose of a POSC is to ensure that infants and caregivers affected by prenatal substance exposure receive needed supports and services after hospital discharge. The POSC plan has been integrated into the workflow of each birthing hospital. Families work with the birthing hospital care team to create the POSC, which lists current supports and services and new referrals. Each POSC is tailored to the infant and their caregiver(s) with resources and services that will help support them when they go home from the hospital. Examples of services include Family Visiting, Early Intervention, and recovery supports such as medication assisted treatment.

Work has begun to build POSC into KIDSNET, the State's secure database for critical information about children's health. This will ultimately facilitate the statewide completion, collection, and appropriate sharing of POSCs. Through an existing mechanism, completed POSCs are collected from the birthing hospitals and securely delivered to the RIDOH SEN Program. POSC data is entered and analyzed monthly. Under the federal mandate, aggregate POSC data is reported annually to DCYF. A POSC is a care coordination tool, which is meant to be used, consulted, and revised throughout the family's engagement. Further, POSCs should be a part of warm hand-offs, and updated to inform and support the family's care as long as the family is engaged in services.

First Connections NAS Program

Launched in 2019, the First Connections NAS Program (FC-NAS) is an enhancement to First Connections, RI's existing short-term, family visiting program which assesses risk and helps connect families to needed services. Its purpose is to deliver First Connections with an enhanced specificity to meet the unique and complex needs of families with NAS infants. The enhancements include engaging the families *before* hospital discharge and working with them post-discharge; providing care coordination through case conferencing, and continuity-of-care through warm hand-offs; and paying extra attention to the behavioral health needs of the mother.

Although the focus of FC-NAS is primarily families with infants with an NAS diagnosis, all families with SENs are eligible to participate. Prenatal substance exposure in all forms constitutes increased risk to infants and families, and they may benefit from the enhanced and focused support that FC-NAS offers. As part of FC-NAS, an NAS Liaison is embedded at Women & Infants Hospital.

FC-NAS improves the proportion of NAS families who have a documented POSC. Prior to FC-NAS, approximately 50% families with substance exposed newborns had a POSC and 72% of FC-NAS

participants had one. FC-NAS increased the percentage of NAS families who received at least one First Connections home visit from 36% to 73%.

Pediatric/Specialty Care (with expertise in substance exposed children)

All families with an NAS infant are referred to The Brown Center for Children and Families which provides evaluation and services to infants and young children with history of opiate exposure during pregnancy. Services include medical, psychosocial and developmental evaluation as well as support services for families, including play therapy and individual and family therapy. This clinic serves graduates from the Family Care Unit at W&I hospital and infants born at other hospitals. Babies are referred upon hospital discharge and are seen at interval visits until 2 years old. It is currently the only specialty care clinic for these infants and young children and their families in Rhode Island. Currently, there are no wait-times for appointments for newborn referrals to the Family Care Follow-up Clinic. The "no show" rate is 50%.

These children also receive primary care through regular well child visits, sick and follow-up visits as needed, with their primary pediatric provider from the newborn period and throughout childhood. After age 2, these children are referred for specialty care as needed by the PCP if there are concerns such as developmental delay or behavioral issue(s) which are not specific to this population. Families report that community-based pediatric care for substance exposed newborns can be inconsistent and some providers are not well-versed in the nuances of caring for a substance exposed infant or a parent with SUD and/or on MAT. Some physicians have contradicted SAMSHA guidance around breastfeeding, and parents report instances of bias and discrimination. Additional training for primary care providers on caring for substance exposed children may improve care for these children.

Prevention, Intervention, or Recovery Support

Community Education and Awareness

In 2019 - 2020, the Substance Exposed Newborn Task Force developed a strategic plan and identified the need to implement a public awareness campaign for pregnant and postpartum individuals with the goal of normalizing and increasing awareness of recovery and treatment options, and reducing bias. For the past six months, RIDOH has been working with a marketing firm to design a culturally fluent, non-judgmental, respectful and trauma-sensitive campaign. Launching of the plan has been delayed due to COVID-19 and funding challenges. RIDOH anticipates releasing the campaign in early 2021.

Screening

Currently, RI does not have universal screening protocols in place for providers. In 2018, BHDDH conducted a campaign with MAT providers to utilize the One Key Question ("Do you plan to be pregnant in the next year?") during appointments but there is a need to expand this to other providers, especially obstetricians/gynecologists. Family visiting programs also systematically screen for substance use disorders. All MIECHV-funded programs, Early Intervention, and Early Head Start include at least one question about substance use during their intake assessment. Continuing to expand and standardize screening protocols remains an important priority for RI. Encouraging and supporting all providers to utilize "One Key Question" while proactively addressing pregnancy intention and family planning strategies and resources before, during, and after pregnancy is a key strategy of the Substance Exposed Newborn Task Force.

Needle Exchange Sites

Needle exchange sites and harm reduction services can minimize bad outcomes and provide opportunities to engage individuals in additional services. There are several places in RI with free syringe exchange services - ENCORE has a storefront in Providence and a mobile team that travels to several areas in RI including Providence, Central Falls, Pawtucket, Cranston, and Newport. Project Weber/RENEW has a main drop-in center in Providence and a street outreach team.

Naloxone

In RI, naloxone is available at pharmacies without a prescription from a doctor and at some community-based organizations like AIDS Care Ocean State, East Bay Recovery Center, Parent Support Network, Project Weber/RENEW, and RICARES. All health insurers in RI cover at least one type of generic naloxone with a no-cost/low-cost co-payment and Medicaid fully covers the cost of generic naloxone and Narcan®.

24/7 Crisis Resource Line and Triage Center

BH Link Hotline, (414-LINK; 414-5465) is a one-stop, statewide 24/7 call-in center that connects people to appropriate care and resources, when they or someone they care about is experiencing a behavioral healthcare crisis.

Peer Recovery Specialists

Certified peer recovery specialists (CPRS) provide non-clinical, peer recovery support services as an adjunct or alternative to specialized, professionally directed substance use treatment. In an emergency department setting, CPRS engage with people presenting with a substance use crisis and/or overdose. CPRS are uniquely qualified to offer support and encouragement because of their lived experience and training. Peer support provided in the Emergency Department setting is so effective that it can literally change the course of someone's life and recovery.

The Parent Support Network offers Healing Mother & Baby, a program for mothers of newborns impacted by prenatal substance exposure. PSN's cadre of specially-trained pregnant and parenting peer recovery specialists work with clients to coordinate medical, behavioral, and social services including community-based supports, provide parenting education, provide linkages to Family Treatment Drug Court[28], Safe and Secure Baby Court[29], and DCYF, do warm transfers to OBGYN/appts, and support collaboration with birthing hospitals. DCYF refers to this program as does the First Connections NAS program and other providers. There are also certified peer recovery specialists at various DCYF locations and Family Treatment Drug Court.

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[28] *Rhode Island Family Treatment Court works to protect children whose health and welfare may be adversely affected by parental substance use. The court: (1) identifies substance-involved parents on the court docket and through partnership with community-based service providers; (2) develops comprehensive multi-disciplinary case plans in collaboration with the child welfare system; (3) facilitates participants' access to treatment and other services; and (4) assesses progress through intensive follow-up, service provider reports, surveys/other data collection, and frequent court supervision of court orders.*

[29] *The Safe and Secure Baby Court Rhode Island Family Court was established to improve parents' and children's experience of the child welfare system. The idea is to improve collaboration between the court, child welfare, infant mental health providers, and other community resources to expedite and enhance services to help parents cope with challenges and heal, a key component for building healthy relationships with their babies. When parents are engaged as respected members of the team it becomes more likely that the developmental needs of babies are met.*

Even with CPRS in a large number of settings including Recovery Centers, there is still a need for more peer recovery coaches with lived experience birthing and/or parenting with SUD. PSN has recently received a HRSA grant to increase the peer recovery workforce. The state has also recently implemented new policies to allow Certified Peer Recovery Coaches to bill Medicaid and has streamlined the certification process to encourage certification. However, to date this has not been enough to increase the pool of Certified Peer Recovery Coaches that can bill Medicaid.

Recovery Housing

Recovery housing in RI is funded by grants and private pay. There are five recovery houses for women in the state, located in Providence, Warwick, and Central Falls. Pregnant individuals are prioritized for these beds. There are two recovery houses that allow children - Amos House has two houses (1 for women, and 1 for males) and there is one other house that is in the process of implementing a program that will allow children. There are currently no recovery residents that specialize in families, housing both parents and children together.

Currently there are 20 women actively waiting for a spot. The number that are pregnant or parenting is not known. The average wait time for individuals who have been placed in recovery housing is 41 days. Men wait an average of 28 days. This wait only impacts people who are seeking financial assistance from the state. Private pay clients can generally access recovery housing much sooner.

It is also worth noting that financial assistance is paid for by SOR grant funding. Under the original SOR funding requirements, payment for recovery housing for anyone with opioid use disorder (OUD) or at risk for OUD was allowable. This extended to recovery from alcohol addiction as well. With the most recent SOR allocation, funds may only be used to pay for recovery housing for people in recovery from opioids and/or stimulants. BHDDH is currently exploring options for providing financial assistance to people who do not meet the new SOR requirements.

Bereavement Services

Friends Way offers free bereavement services for children, ages 3 to 18 and their families following the death of a significant person in their lives.

Gaps in the Current Level of Treatment and Prevention, Intervention, and Recovery Services Available

An analysis of qualitative and quantitative data, indicates that there are ten gaps in the current level of treatment and prevention, intervention, and recovery services available.

Not enough residential inpatient treatment beds for the whole family: The majority of individuals entering treatment have children. These children are at high risk of child abuse and neglect, developmental problems, and adolescent substance use. When whole families are treated, and families are kept together, outcomes for each individual member improve. Simultaneously the communication, coordination, and ability of adult members to support one another and the children increase. Currently RI has one facility that keeps the parent and children together during treatment but only if the parent is medically and mentally stable and post-partum. RI does not have a facility for parenting individuals in need of treatment nor does it have a medically monitored facility for pregnant and postpartum individuals with acute mental

or physical health needs that are not severe enough for medically managed inpatient services but too acute for residential services. The capacity is not sufficient to meet the needs of the current population of pregnant, postpartum, and parenting individuals with SUD.

Need to increase screening and identification of SUD: Currently, RI does not have universal screening protocols in place for providers. In addition, focus group participants reported that providers profile patients, making bias-based assumptions about who needs to be screened. They are often wrong, and opportunities for identification are missed. Statewide screening protocols would improve the consistency of screening practices.

Need for more peer recovery coaches for pregnant and postpartum parents with SUD: Frontline staff and providers stressed that peer recovery specialists provide critical coordination and support, and more are needed. Pregnant people, who are using substances or in treatment, and their families desperately need more peers to help them navigate pregnancy, birth, and parenting while getting help for substance use.

Need recovery housing for families: Allowing families to be together in recovery housing not only benefits the parents, but also is a benefit to children. Parents are more likely to keep custody of their children, reducing the impact of trauma associated with separation for both parents and their children.

Need to continue professional development and training on maternal substance use and substance exposed children for frontline staff: Frontline staff who work with families confirmed a continued need for ongoing professional development around parental substance use and substance exposed children. To advance this goal, RIDOH coordinated an Intensive NAS Training in April 2020 for First Connections and Early Intervention family visitors. The four-part training covered the clinical aspects of NAS, including feeding, sleeping, and dysregulation, and was attended by almost 100 participants. The state would like to sustain this training so that all new hires can receive it. There will also be a need for refresher training for incumbent workers as research and guidance evolve.

Need to develop and disseminate a policy statement that will help to inform messaging to families about the danger of marijuana use during pregnancy: There is a misperception of safety associated with marijuana use during pregnancy; the perception of harm is decreasing while the rate of use is increasing. Currently, in Rhode Island medical marijuana is legal and recreational marijuana is not. With medical marijuana now legal in Rhode Island there has been an increase in the number of newborns hospitalized for associated complications. Approximately 50% of substance-exposed infants in Rhode Island have been exposed to marijuana in utero. Providers report needing more guidance on how to address marijuana exposure and talk about the effect of use during pregnancy on fetal and infant outcomes with families.

Need more care coordination and communication between medical providers and behavioral health providers: Behavioral health (as the umbrella term for both mental health and substance use) and medical issues frequently co-occur. Illnesses such as heart disease, cancers, diabetes, and neurological issues can carry with them behavioral health consequences. Coordination of medical and behavioral healthcare with a focus on wellness is critical to improved health outcomes, especially for chronic illnesses. However, very few medical providers such as primary care doctors and obstetricians are communicating with their patient's substance use treatment providers or other members of the care team. One of the primary reasons for this is negative biases about and lack of understanding of medication assisted treatment among primary care providers (PCP). Patients are aware of this stigma and are therefore unwilling to sign releases to

disclose information to their PCPs. And when they do, their PCPs can be unwilling to coordinate closely with SUD providers.

Not enough access to long-term recovery supports: Recovery can take a long time. The current health care system in RI, is structured to support transactional and time-bound clinical outcomes. This structure does not typically provide continuous support for people in their recovery over the long-term. Limiting or ending support for recovery services too soon can disrupt progress and increase the risk of relapse. For example, when an individual on Medicaid is pregnant insurance coverage is enhanced. Within a few weeks after delivery, the enhanced elements are gone. For individuals with SUD the first postpartum year is fraught with an increasing high risk of relapse and overdose. Enhanced insurance coverage can provide critical support to individuals in that first postpartum year.

Not enough access to safe and affordable housing: Recovery requires a stable home, and decent, safe, affordable housing is one of the most important factors that affect behavioral health, and is one of the hardest to access. Lack of housing or poor housing, can lead to poor overall health. It can also make recovery from substance use disorders and behavioral health problems much more difficult. In addition, people with substance use disorders are vastly overrepresented in the population of those who experience homelessness.

Not enough access to sustainable employment opportunities: Balancing treatment and the need to work is really challenging. Unpredictable employment schedules make it hard to fulfill required toxicity screens and keep appointments. While supported employment is a billable Medicaid service, it is currently under-utilized in RI for people with mental health and substance use disorders.

Barriers to Receipt of Substance Use Disorder Treatment and Counseling Services

An analysis of qualitative and quantitative data, indicates that there are three main barriers to the receipt of substance use disorder treatment and counseling services.

Not enough access to critical social supports: Families affected by substance use disorder can experience profound challenges. Social determinants of health such as access to economic and educational opportunities, transportation, and quality childcare are inexorably linked to families' abilities to transform their lives in the face of the disease of addiction. Focus group and survey participants stressed that factors such as poverty, and access to transportation and child care are vital elements that impact self-determination, health, and well-being. The hardest and most important supports to access include:

- ***Transportation:*** Transportation is one of the biggest barriers to seeking treatment and maintaining medical appointments. It is difficult to get to both treatment facilities and medical appointments via the public transportation system, especially in Woonsocket where buses only run until 5 pm. The state subsidizes transportation for Medicaid-eligible residents but rides must be scheduled at least 24 to 72 hours in advance and no more than one ride can be scheduled per day. This does not allow for unexpected sick visits to the pediatrician and requires people to take time off of work over multiple days if they need to schedule multiple appointments. Aligning bus routes with health care providers and treatment locations would help to alleviate this barrier.
- ***Child Care:*** Most individuals seeking treatment are parents and need child care (often in the office) for their children so that they can participate fully in treatment, and secure and sustain stable

employment. Affordable child care is hard to find in RI and not all providers offer in-office child care during appointments.
- ***Legal/Court Services:*** Families need help with legal issues around substance use during pregnancy and custody after delivery.

Finally, expanded rules, via the Governor's Executive Order, around conducting provider visits remotely (telehealth) during the pandemic has significantly increased attendance and reduced no-shows for provider visits, especially for patients with transportation and child care concerns.

Need to address negative perceptions and fear of DCYF: Focus group and survey participants, especially women of color, expressed significant and persistent fear and mistrust of DCYF. They do not trust that decisions about parental rights are made based on consistent criteria, or that all investigators share the goal of keeping the family together. This deters them from seeking help even though they want what is right for their baby. They also noted that because DCYF does not get involved with the family until there is a child, there are missed opportunities to support recovery and keep families together. This often leads to sudden, traumatic separations. In addition, parents perceive family visiting to be an arm of DCYF and are afraid to engage with much needed support because they are afraid it will lead to DCYF involvement.

Need to address gaps exacerbated by COVID crisis: The crisis has laid bare the inequities and injustices that threaten the well-being, safety, and lives of RI families living on the margins. There are high and increasing rates of hardship especially with employment, income, and food sufficiency. All of these hardships affect and can potentially derail recovery[30] making it critical that the State of Rhode Island move quickly to close gaps in basic needs.

Opportunities for Collaboration with State and Local Partners

Families with young children often touch many programs and systems which are be overseen by multiple state agencies. This can create fragmented systems, inconsistent policies, duplication of services, or barriers to accessing services. It is essential that state partners work together and include community partners to solidify a seamless system of services for families. RI has worked hard on consistent assessments, coordinated referral policies and comprehensive care coordination. These efforts are ongoing between state agencies and include community partners. One current opportunity for deeper collaboration between state partners is alignment and integration of data to support decision-making about treatment capacity.

Currently, there is no single data source for licensed treatment practitioners and providers in RI that includes detailed information regarding treatment and services available for specialized populations such as pregnant and postpartum individuals. Different agencies hold different roles in the system; BHDDH provides licenses to facilities providing mental health services for adults and substance use disorder services for all ages, RIDOH provides licenses to independent practitioners and hospitals, and DCYF provides licenses to mental health providers for children under 18. Each agency keeps data on their licensed providers and practitioners separately with varying levels of detail regarding populations served. BHDDH is currently in the process of developing a website that lists all available treatment facilities by

[30] *Since April 2020 (the first full month of sheltering in place) there has been an increase in suicides, incidents of domestic violence, and accidental overdose deaths. In addition, there has been more than a 238% increase in alcohol purchased online, and a 1500% increase in participation in online alcohol drinking parties among 18-24-year olds.*

type, and publishes bed capacity and waitlist information. At this time there is not an equivalent source of public data for outpatient treatment or independent practitioners. In addition, while SAMHSA maintains a treatment locator website for each state, the data on this site does not match local data. To continue to improve the state's capacity for providing substance use disorder treatment and counseling services, it is important to continue to work to improve the integration and alignment of data on treatment availability.

Current Activities to Strengthen the System of Care for Addressing Substance Use Disorder

RI has several current activities and initiatives in place to strengthen systems of care for addressing substance use disorders (SUD).

SEN Task Force: the Rhode Island Task Force to Support Pregnant and Parenting Families with Substance Exposed Newborns (SEN Task Force) is comprised of a broad array of multidisciplinary professionals, state leaders, and community providers and partners who share a vested interest in creating better systems of care for families and children affected by substance use. The SEN Task Force reports to the Governor's Overdose Prevention Task Force and the Rhode Island Children's Cabinet. Five workgroups currently report up to the Task Force. In 2019, the Taskforce developed a statewide strategic plan for substance exposed newborns focusing on four priority areas: policy and regulations; multi-disciplinary teaming and family centered care coordination; longitudinal and integrated recovery resources; and professional development training for providers and frontline staff.

Substance Exposed Newborns Interagency Coordinating Team (SEN I-ACT)**:** In August 2018, the Substance Exposed Newborns Interagency Coordinating Team (SEN I-ACT) was established. The SEN I-ACT, composed of representatives from RIDOH, BHDDH, EOHHS, DCYF, and the Governor's Office responds to time-sensitive concerns with one robust interagency voice. Along with formalizing interagency collaboration, it ensures the state is well-poised to leverage additional resources as they become available.

SOR Pilot: In May 2019, with State Opioid Response (SOR) funding, RIDOH began piloting a program that brought First Connections, the state's short-term, RI-based family visiting program, into Women and Infants Hospital. This pilot provided NAS infants and their families with a warm hand-off to local First Connections agencies before hospital discharge. RI is planning to sustain integration of this pilot into the First Connections model as a matter of regular practice.

CAPTA eReferral System: DCYF has begun a collaborative cross-system effort to build a referral and tracking data system to support and manage the CAPTA referral process. A cross-system group of data and program management staff continued meeting during FY 2019 and has evolved into the Child Fatality Prevention Workgroup. This group has initiated development of the cross-system referral and tracking system and has begun an interim process of tracking the outcome of referrals to First Connections and Early Intervention. Ongoing development of this system will ensure that the department and its cross-system partners will be able to maintain awareness of the rate of engagement in supportive services following a CAPTA referral. This process and system will allow the department to shift and manage practice approaches to better attend to child safety and child well-being related to the vulnerable population. This work is also being developed in collaboration with the statewide EI/ Child Welfare Workgroup in order to include input by all stakeholders involved in the process.

Rhode Island Children's Cabinet: During the course of 2020, the Cabinet has continued to focus attention on the needs of young children in the child welfare system. The Cabinet is state department directors that meet monthly to work toward implementing policies and programs to better meet the needs of RI's most vulnerable children. As a part of the Children's Cabinet work, DCYF has entered the third year of the Rhode Island Getting to Kindergarten Grant funded by the W.K. Kellogg Foundation. Project grant staff and grant funded financial resources have been dedicated to development of the above-mentioned referral tracking system and other related activities to support the developmental and educational well-being of young children in the RI child welfare system.

Moms PRN: This year, MomsPRN is working with RIDOH to expand their focus to include substance use disorder.

Child Wellbeing Workgroup: This workgroup, convened by EOHHS, focuses on all topics related to child well-being including substance use, and identifies needed policy changes.

Optional Considerations: Availability of Wraparound Services

This section provides an overview of the availability of wraparound services to prevent and support treatment of substance use disorders, such as mental health services, housing assistance, and other prevention and support services.

In addition to the components outlined above, RI has several wrap around services to prevent and support treatment of substance use disorders including services working with families to provide support, case management, care coordination, connection to resources, and stabilization. Family supports include:

Family visiting: Family Visiting is a service delivered to families during pregnancy and through the early years of a child's life that links expectant and new parents with a nurse, social worker, early childhood specialist, or paraprofessional who is trained to work with families in their homes. As described in the prior section, there are several family visiting services available to families in RI including: First Connections, Project Connect, Early Intervention, Family Care Community Partnership, Healthy Families America, Early Head Start (home-based option), Nurse-Family Partnership, Positive Parenting Programs, and Parents as Teachers.

MOMsPRN: All health care providers who encounter pregnant and postpartum patients can utilize this free service to ask general questions about perinatal mental health or substance use, or specific questions pertaining to a particular patient. Questions may be about diagnosis and treatment of a specific illness, use of a particular medication, use of a screening tool, help with locating community resources (e.g. individual therapists, support groups) or anything else that will help address mental health and substance use concerns. Community-based providers such as family visitors and peer recovery specialists can also access this resource to get help with locating substance use disorder related resources for families.

Coordination with Title V MCH Block Grant, Head Start, and CAPTA Needs Assessments

Coordination on Data Collection and with Other Needs Assessment

Within RIDOH, the Title V and MIECHV teams came together to coordinate data collection for the MIECHV needs assessment and Title V MCH Needs Assessment. Joint data collection included:

- Surveys of 476 community members and 449 early childhood professionals regarding maternal and child health needs facilitated by Abt Associates.
- Targeted focus groups in communities experiencing stress facilitated by RIDOH staff and Abt Associates
- Focus groups with existing local and statewide stakeholder meetings facilitated by RIDOH staff and Abt Associates including: Family Visiting, Parent Caregiver Advisory Council, Local Implementation Teams (LITs), Thrive by Five, Interagency Coordinating Council (ICC), Successful Start, and the HEZ Learning Collaborative. Conference members were split into smaller focus groups by geographic region and were all assigned family visiting as a topic to discuss and give feedback on.
- Survey of 200 womxn of color in urban areas conducted by SISTA FIRE.
- Findings from prior SISTA FIRE research that focused on the experiences this community has had at the Women & Infants Hospital during pregnancy, delivery, and postpartum - drawn from both their birthing story collection and a 2017 community-wide survey (approx. 300 responses).
- Surveys of family visiting agencies regarding program quality and capacity.
- Interviews of state programs leads for Early Head Start, CAPTA, Early Intervention to identify key needs and gaps. Note: None of these programs had a recent needs assessment available.

Convening Stakeholders to Review and Contextualize Results

To synthesize the data, the MIECHV team convened a cross-program team of family visiting program leads to provide context, interpret the findings, pull out themes and translate it into actionable information. Participants were asked to review and analyze the data and capture insights and notes using a shared worksheet. Then the team convened for a half day retreat to collectively share and reflect on their findings. Then, these findings were shared, discussed and refined at a meeting with all managers of family visiting programs statewide.

Themes from Other Needs Assessment that Informed or Validated Our Findings

The team also reviewed findings from the statewide input gathered to inform both the statewide Family Visiting Strategic Plan in 2019-2024 and the 2020-2025 statewide Substance Exposed Newborn Strategic Plan, and the family and workforce needs assessments funded through the Preschool Development Grant (PDG) in 2018. These sources validated several common and often repeated themes.

Conclusion - Major Findings

RI has made significant strides toward a coordinated system of services for families with young children, with family visiting as a cornerstone. While program capacity has significantly increased in the past ten years, it remains insufficient to meet the needs of all RI families who could benefit from the positive impacts of services. RI identified eleven communities in which the needs for services far outweighs the capacity. This needs assessment also highlighted some populations, who do not able to access services due to perceived and real barriers. RI needs to expand its capacity to meet the needs of pregnant individuals and families with young children to achieve the best possible outcomes with a particular focus on families experiencing disparities, and substance use. Within racially and linguistically diverse communities, RI needs to do additional work at the local level to help families understand how family visiting can benefit them and be a service they may want to access. Continuing to work to ensure that the infrastructure of early childhood services, including family visiting, can support programming is also important. RI needs to work to access state funding which will help support better wages and support for the essential workforce providing family home visits. The current crisis of COVID-19 has brought this problem even more to light as family visitors provided basic needs to families who got sick or were in quarantine. While a very challenging time, it reiterated the need to ensure that RI has a strong family visiting system.

This needs assessment will be used within the broad early childhood system among multiple state and community partners to inform local program and policy development, advocate for funding and program expansion, and inform the state level decision making process. All stakeholders will receive a copy of the needs assessment. The findings will be shared and discussed at local and statewide meetings, such as the Local Implementation Teams, the Early Learning Council, the Parent/Caregiver Advisory Council and at the Children's Cabinet. A summary of the needs assessment will also be placed on RI's early childhood web page for more broad accessibility. The needs assessment will be particularly informative as the state seeks to create a multi-state agency behavioral health system that supports all of its citizens. It will also support the multi state agency work to support all children to achieve grade level reading by the third Grade. The availability of this information to support statewide efforts to improve services in essential to creating a solid framework of supports for families based on the understand of their actual needs.

RI has appreciated the opportunity to conduct this comprehensive needs assessment. It has been extremely informative and will support the ongoing high-quality programming for families and children who are facing adversity. It will support the state to continue to meet emerging needs of the families in RI on an ongoing basis.