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Substance Use and Mental Health in Rhode Island (2015): A State Epidemiological Profile

Samantha R. Rosenthal

Johnson & Wales University - Providence, Samantha.Rosenthal@jwu.edu

Christina Hom

Brown University

Stephen Buka

Brown University

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SUBSTANCE USE AND MENTAL HEALTH IN RHODE ISLAND (2015)

A STATE EPIDEMIOLOGICAL PROFILE



PREPARED BY

Samantha Rosenthal, PhD, MPH

Brown University School of Public Health

Center for Population Health and Clinical Epidemiology

State Epidemiological Outcomes Workgroup (SEOW).

November 2015

INTRODUCTION

The purpose of this report is to identify and present documentation on substance use (i.e., alcohol, tobacco, and other drugs) and mental health indicators for both adults and youth in the state of Rhode Island as compared to the United States. Additionally, Rhode Island was also compared to other neighboring and regional states in the New England (CT, ME, MA, NH, RI, VT) and Northeastern (NY, NJ, PA) regions.

The report is designed to be used as a resource by various RI state agencies, such as the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH); the State Epidemiological Outcomes Workgroup (SEOW); and the many community-based Substance Abuse Prevention Task Forces in RI.

It is important to note that this is a working document. The 2015 Rhode Island State Epidemiological Profile is understood to be an evolving document, to be improved and updated regularly both with additional indicators and years of data, when available.

ACKNOWLEDGEMENTS

Thank you to SEOW membership and those who attended the November 30, 2015 meeting and voted to endorse this report. The SEOW membership can be found in the Appendix. Funding for this report comes from the Substance Abuse and Mental Health Services Administration Award number U579SP020159.

The Brown University Team

- Stephen Buka, ScD
- Samantha Rosenthal, PhD, MPH
- Christina Hom, MPH

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

- Maria Montanaro, MSW, Director
- Elizabeth Kretchman, CPSS, Prevention Coordinator
- Linda Barovier, CPSS, SPF-PFS Coordinator

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EXECUTIVE SUMMARY

The purpose of this report is to identify and present documentation on use (i.e., alcohol, tobacco, alcohol and other drugs, or other substances) use and mental health issues indicators for adults and youth in the state of Rhode Island as compared to the United States. Additionally, Rhode Island was also compared to other neighboring and regional states in the New England (CT, ME, MA, NH, RI, VT) and Northeastern (NY, NJ, PA) regions.

The Profile is guided by an outcomes based framework, and as such, it identifies specific areas of need, as well as potential risk and protective factors, from several ecological levels. Data summarized in the Profile can be used to inform and assist in data-driven state- and community-level planning and decision-making processes relevant to substance use and mental health issues across the state of Rhode Island by providing a comprehensive set of key indicators—micro to macro level—describing the magnitude and distribution of:

- Substance use consumption patterns (e.g. alcohol, tobacco, and other drugs), as well as their adverse consequences across various populations (e.g. youth, adult, racial/ethnic sub-populations).
- Mental and behavioral health outcomes.
- Potential risk and protective factors associated with substance use and mental illness.

KEY FINDINGS AT A GLANCE

- Recent (past month) use of illicit drugs and marijuana are still major concerns among Rhode Islanders of **all age groups** especially since prevalence rates exceed the national averages. RI excess is greatest for past month marijuana use followed by past month illicit drug use.
- Drug abuse or dependence remains a concern across **all age groups**; and needing but not receiving treatment for drug use is of particular concern among adults aged 26 years and older.
- Black **high school students** in RI as compared to the US are at a higher risk of ever cocaine use and ever methamphetamine use, while Asian and White **high school students** are at a high risk for current marijuana use.
- Substance abuse admissions for heroin from 2012-2014 have dramatically increased. More data are needed to identify the key demographic populations at risk.
- Compared to the US, RI adults aged **18-25 years** have a greater unmet need for treatment for DSM-IV alcohol abuse/dependence.
- RI adults aged **26+ years** have higher prevalence of serious mental illness in the past year, any mental illness in the past year, and having had at least one major depressive episode in the past year relative to national averages.
- Drug-related overdose deaths are a primary concern for RI. Data collection that can distinguish between prescription drug and street drug overdose is needed to better understand the nature of this problem.

METHODS

Sources of data included in the Profile are those that provide behavioral health outcomes, with valid and reliable national estimates over time, as well as regional or state comparisons. Some state-specific data have been included to further investigate areas of interest (e.g. drug overdose data). The sources of data compiled in the Profile are often publically available, yet the Profile offers several distinct advantages by:

- Combining, summarizing, and presenting all relevant data in a unified, easy-to-read manner.
- Providing national and regional comparisons for the selected key indicators.
- Providing temporal trends for the selected key indicators.

This reports relies heavily on comparison of state to national averages. Indicators were deemed concerning if Rhode Island was 15% or more above the national average or promising if Rhode Island was 15% or more below the national average.

KEY FINDINGS

1. RHODE ISLAND DEMOGRAPHIC AND SOCIODEMOGEOGRAPHIC CONTEXT

- RI is located in the New England region of the Northeast of the United States. It is geographically the smallest US state with an estimated population at 1,052,567, with the majority of the population being ethnically or racially White and over 20 years of age (Table 1.4.0).
- RI as compared to the US has a larger elderly population (aged 65+), with a larger proportion of persons ages 25+ having a bachelor degree or higher (Table 1.4.1).
- The unemployment rate in RI has decreased over the past year; however, the unemployment rate still remained higher compared to the national average and MA (Table 1.4.2, Figure 1.4.2).
- As evident from data shown in Table 1.4.3, RI as compared to the US and regional states had a lower prevalence of homeless population.
- Health insurance coverage in RI (9%) was comparable to other northeastern states and was better than the national average (13%) regarding the uninsured rate (Table 1.4.4).

2. SUBSTANCE USE

- RI as compared to the US across **all age groups** (12+ years) over time fare worse with higher prevalence rates for any illicit drug use in the past month, marijuana use in the past month, and DSM-IV drug abuse or dependence.
- RI adults **aged 26+** report needing but not receiving treatment for drug use more than US averages.
- **All age groups** (12+ years) of Rhode Islanders perceive less risk of smoking marijuana once a month than the national average (Table 2.1.2); 18-25 year olds had the least concern over monthly marijuana use relative to the national average.

- There have been significant increases in the number of substance abuse admissions for heroin from 2012-2014 (Table 2.1.6), and slight increase in the number of substance abuse admissions for minors and 22-30 year olds.
- Among the **high school student** population, RI fares better than the national average for smoking cigarettes, use of tobacco before age 13, use of marijuana before age 13 and prescription drug misuse in the past year.
- Additionally, when reporting by racial or ethnic disparities in **high school youth**, RI Black high school students as compared to national averages were at a higher risk for ever cocaine use and ever methamphetamine use (Table 2.1.10).
- Asian and white RI **high school students** have higher prevalence of current marijuana use compared to national averages (Table 2.1.10).

3. ALCOHOL USE

- Alcohol consumption across **all age groups** in RI as compared to the US was larger in prevalence. In particular, the **18-25 age group** was at the most risk for alcohol abuse or dependence and needing but not receiving treatment for alcohol use.
- Alcohol consumption indicators for **high school students** including past month use, binge drinking in the past month, use of alcohol before age 13, drinking and driving in the past month, and being in the car with a driver who had been drinking in the past month, all had lower prevalence in RI as compared to the US in the past three data collection points (2009, 2011, and 2013; Table 2.2.3).
- As evident from data shown in Table 2.2.4, when alcohol consumption for **high school students** were compared regionally, RI high school students were lower in prevalence compared to other regional states for ever had at least one drink of alcohol and binge drinking in the past month.

4. MENTAL HEALTH

- Tables 2.3.0 and 2.3.1 show that **children** in RI as compared to national averages have more emotional and mental health problems; specifically, RI fares worse for children 4 months to 5 years whose physical, behavioral or social development is of concern to their parents, children 4 months to 5 years who are at high risk for developmental, behavioral or social delay, children age 6-17 years who often exhibit problematic social behaviors, children age 2-17 years who currently have moderate or severe ADHD or ADD, and children age 2-17 years who currently take medication because of difficulties with emotions, concentration or behavior.
- Additionally, **children** aged 10 months to 5 years in RI as compared to the US were less likely to receive developmental screening in the past 12 months (Table 2.3.1).
- In 2013-14, RI adults across **aged 26+** had a higher prevalence of serious mental illness in the past year, any mental illness in the past year, and having had at least one major depressive episode in the past year relative to national averages.
- In 2013-14, RI adults had a higher prevalence of any mental illness in the past year than all other Northeastern states (Table 2.3.3).
- In Rhode Island, the number of mental health treatment admissions by **minors (<18)** has increased substantially from 2012 to 2014, while treatment admissions for **seniors (65+)** have decreased (Table 2.3.4).

5. CONSEQUENCES

- As evident from data shown in Table 2.4.0, several long-term adverse consequences remain elevated in Rhode Island, as compared to the national averages. This is especially the case for diseases of heart deaths, chronic liver disease and cirrhosis deaths, deaths from fatal motor vehicle crashes involving alcohol, DSM-IV alcohol abuse and dependence, and DSM-IV drug abuse and dependence, whose rates have remained greater in Rhode Island relative to the national averages from 2004 to 2012.
- Similarly, in 2012 RI is highest among all states in the region for chronic liver disease and cirrhosis deaths, fatal motor vehicle crashes involving alcohol, DSM-IV alcohol abuse and dependence, and DSM-IV drug abuse and dependence (Table 2.4.1).
- Drug-related overdose deaths per 100,000 population were significantly higher in RI than in all other states in the region and almost twice the national average (Table 2.4.2 and Figure 2.4.2).
- Emergency department visits in RI for prescription drug overdose have increased from 2010 to 2014; approximately one quarter of visits were for residents under the age of 21 years (Table 2.4.3).
- Hospital admissions related to prescription drug overdose in RI have actually decreased from 2010 to 2014; about 17% of admissions were for residents under age 21 years (Table 2.4.3).
- In 2013 RI **high school students** report a significantly higher rate of attempting suicide (Table 2.4.4) than national averages, despite having lower rates of considering suicide and planning suicide ; however, this rate subsided in most recent 2015 YRBS data.

6. DATA LIMITATIONS AND GAPS

Even though this Profile seeks to provide a comprehensive summary of substance use and mental health-related indicators and risk or protective factors in the state of RI, there are data-related limitations the reader should keep in mind.

- The Profile is limited by the availability, accuracy and comprehensiveness of the original sources of data. Therefore, most recent years of data or demographic break-downs of indicators may not always be available. Every effort will be made to keep the Profile up-to-date.
- It is recommended that the reader review the Appendices, Data Sources to better understand the advantages and limitations inherent in each of the original data sources used for this Profile.
- Data provided in this Profile are presented without any demographic adjustments. Also, confidence intervals for these estimates were not included.
- Additionally, due to the data provided in this Profile are presented in crude form, the relationship between substance and alcohol use and short- and long-term consequences are not causal.
- At this time, the Profile focused primarily on the underage population as the key demographic sub-group of interest. Additionally, demographic breakdown to include racial and the start of health-status breakdowns were added to this version. Future versions will aim to continue and extend demographic breakdowns to other populations of interest, and include more racial, gender, and health-status breakdowns.
- Rhode Island is densely populated, highly urban, and the smallest state in the US. It is also in close proximity to other large cities in the New England corridor (e.g. Boston, New York City).

7. SUMMARY

The Profile contains most relevant data on statewide substance use and abuse (consumption patterns), alcohol consumption patterns, mental health, short- and long-term consequences, and risk and protective factors. Additionally, substance use and abuse, alcohol consumption patterns, and short- and long-term consequences by RI versus national averages and RI as compared to regional states including the New England and Tri-State regions. New to this Profile are more in-depth background and RI demographic context. This Profile included more data of population, age groups, specific racial and ethnic groups, foreign born and language, education, income, labor force data including unemployment rates, homelessness status, and health insurance coverage.

In addition, this Profile provided data by age group and time-trend for many of the topics presented. Keeping the inherent limitations in mind, the data summarized in the Profile can therefore be utilized for promotion, prevention, treatment, recover and health-care planning for the State of Rhode Island.

1. INTRODUCTION

1.1. BACKGROUND

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), the single state authority for substance abuse prevention and treatment and the state mental health authority, established the State Epidemiological Outcomes Workgroup (SEOW). BHDDH and SEOW report results of its activities to the Rhode Island Governor's Council on Behavioral Health. BHDDH continues its existing relationship with the Brown University School of Public Health, which has lead responsibility for epidemiologic analyses conducted by the SEOW, and the University of Rhode Island (URI) Department of Psychology that provides prevention evaluation services for BHDDH and the PFS.

The objectives of the SEOW are to: (1) Develop a set of key indicators, micro level to macro level, to describe the magnitude and distribution of substance use, abuse, and consequences, and mental illness as well as to develop a set of key indicators, micro level to macro level, of risk and protective factors associated with substance use, abuse, and consequences, and mental illness across the State of Rhode Island; (2) Identify, collect, manage, analyze, and interpret data on the prevalence of substance use, abuse, and consequences, and mental illness; relevant risk and protective factors at multiple ecological levels; (3) Based on these data, develop and communicate state-level and community-level epidemiologic profiles for promotion, prevention, treatment, recovery and policy implications for Rhode Island healthcare system; (4) Inform and recommend priorities for the State of Rhode Island based on the community and state-level epidemiological profile; and (5) Maintain and expand a systematic, ongoing monitoring system of the prevalence of substance use, abuse and consequences, mental illness, and relevant multilevel risk and protective factors.

As such, the SEOW mission is reflected in this Profile, which offers integrated and comprehensive data on magnitude and distribution of:

- Substance use and abuse, including both consumption patterns as well as short- and long- term consequences.
- Mental and behavioral health outcomes across the State of Rhode Island.
- Risk and protective factors associated with substance use and mental health.

1.2. PURPOSE

The purpose of the 2015 Rhode Island State Epidemiological Profile (Profile) is to inform and assist in data-driven state- and community-level planning and decision-making processes relevant to substance use and mental health issues across the State of Rhode Island by providing a user-friendly and comprehensive set of key indicators -- micro level to macro level -- describing the magnitude and distribution of:

- Substance use consumption patterns (alcohol, tobacco, and other drugs), as well as their negative consequences among various populations (i.e., youth, adults, minority groups).
- Mental and behavioral health outcomes across the State of Rhode Island as well as compared to the United States and regional comparisons.
- Potential risk and protective factors associated with substance use and mental health, highlighting existing health disparities across various populations.

The Profile identifies specific areas of need, as well as potential risk and protective factors at several ecological levels.

1.3. DATA OVERVIEW

The Profile contains most relevant data on statewide substance use and abuse (both consequences and consumption patterns), mental health issues, and relevant risk and protective factors.

- The Profile provides prevalence rates and/or raw counts for key substance, mental and behavioral health indicators of interest, as well as the associated risk and protective factors.
- Data are predominantly summarized in tabular form, with additional graphic representations of key indicators and/or temporal trends.
- Relevant data on sub-populations (i.e., age groups, racial/ethnic groups, etc.) are also provided when available.
- Sources and brief explanations are provided in most instances.
- When available, national and regional comparisons are provided, as well as temporal trends.

The sources of data compiled in the Profile are often publically available, yet the Profile offers several distinct advantages by:

- Combining, summarizing and presenting all relevant data in a unified, user- friendly manner.
- Providing national and regional comparisons for the selected key indicators
- Providing temporal trends for the selected key indicators.

1.4. RHODE ISLAND DEMOGRAPHIC AND SOCIODEMOGRAPHIC CONTEXT

Rhode Island (RI) is located in the New England region of the Northeast of the United States. RI is geographically the smallest US state, bordering MA to the north and east and CT to the west.

The 2010 Census estimates the population of RI at 1,052,567, with the majority of the population being ethnically/racially White and over 20 years of age.

Table 1.4.0 summarizes basic demographic characteristics for the State of Rhode Island, offering comparison with national averages, as well as temporal trends (i.e., data from the 2000 and 2010 Census). In 2010, RI comprised a population that was predominantly White (81.4%), as compared to the US population (72.4%). For both gender and age, RI was similar to the US. However, in terms of age, compared to the US, RI had higher proportions of people aged 20 to 24, 45 to 54, and 65 or older.

Data from the 2010 Census identified Rhode Island as the state with the second smallest population-growth rate in the nation (behind Michigan), with population change of only 0.4% from 2000 to 2010.

Even though this state-wide population growth was minimal, the racial-ethnic composition of Rhode Island changed, such that between 2000 and 2010, Hispanic and non- Hispanic black population increased from 8.7% to 12.4%, and from 4.8% to 6.2%, respectively.

Table 1.4.0. Demographic Characteristics of RI and US, 2000-2010

	2000		2010	
	RI	US	RI	US
GENDER				
Male	48.0%	49.1%	48.4%	49.3%
Female	52.0%	50.9%	51.6%	50.7%
RACE				
White	85.0%	75.1%	81.4%	72.4%
Black or African American	4.5%	12.3%	5.7%	12.6%
Hispanic	8.7%	12.5%	12.4%	16.3%
Asian	2.3%	3.6%	2.9%	4.8%
Other	8.2%	9.0%	10.0%	10.2%
AGE				
Under 20	26.7%	28.6%	25.3%	27.2%
20 to 24	6.9%	6.7%	7.4%	6.9%
25 to 34	13.4%	14.2%	12.4%	13.5%
35 to 44	16.2%	16.0%	14.1%	14.0%
45 to 54	13.5%	13.4%	15.4%	14.6%
55 to 64	8.5%	8.6%	11.5%	11.1%
65 and over	14.5%	12.4%	14.1%	12.8%

Source: United States Census Bureau 2000 and 2010

There also appeared to be considerable within-state movement of the RI population. Providence and Washington counties increased in population between 2000 and 2010. More than 50% of the state's population resides in Providence County and the Providence metropolitan area (U.S. Census Bureau). Finally, most Rhode Island counties experienced either decrease or minimal growth among the youth population (i.e., under 18: U.S. Census Bureau).

Table 1.4.1 summarizes additional demographic characteristics of RI as compared to the US from 2009 to 2014. Population characteristics included are population, age groups, race/ethnicity, foreign born and language, education, and income.

According to the US Census Bureau and State and County QuickFacts, there were a higher proportion of persons 65 years and older (15.5%) in RI as compared to the US (14.1%). On the other hand, there were a lower proportion of persons under 5 years and persons under 18 years in age. Regarding race and ethnicity in 2013, RI as compared to the US still remains predominantly White, non-Hispanic or Latino at 75.3% compared to 62.6%, nationally. For both foreign born persons and language other than English spoken at home, RI as compared to the US had high proportions, 13.1% and 21.1%, respectively.

From 2009 to 2013, in RI for persons age 25+, 85.2% had a high school or higher education and 31.3% had a bachelor's degree or higher. As compared to the US, RI had a slightly larger proportion with a bachelor degree or higher.

An estimated 13.6% of Rhode Islanders are below the poverty level, compared to 15.4% for the entire US. Per capita income for RI was larger than the US at \$30,469 compared to \$28,155. Additionally, between

2009 and 2013, the median RI household income was \$56,361. This median was larger than the national median (\$53,046).

Table 1.4.1. Population Characteristics of RI and US, 2009-2014

POPULATION	US	RI
Population, 2014 estimate	318,857,056	1,055,173
Population, 2013 estimate	316,497,531	1,053,354
Population, percent change - April 1, 2010 to July 1, 2014	3.3%	0.2%
AGE GROUPS		
Persons under 5 years, percent, 2013	6.3%	5.2%
Persons under 18 years, percent, 2013	23.3%	20.4%
Persons 65 years and over, percent, 2013	14.1%	15.5%
RACE/ETHNICITY		
Black or African American alone, percent, 2013 (a)	13.2%	7.5%
American Indian and Alaska Native alone, percent, 2013 (a)	1.2%	0.9%
Asian alone, percent, 2013 (a)	5.3%	3.3%
Native Hawaiian and Other Pacific Islander alone, percent, 2013 (a)	0.2%	0.2%
Two or More Races, percent, 2013	2.4%	2.5%
Hispanic or Latino, percent, 2013 (b)	17.1%	13.6%
White alone, not Hispanic or Latino, percent, 2013	62.6%	75.3%
FOREIGN BORN AND LANGUAGE		
Foreign born persons, percent, 2009-2013	12.9%	13.1%
Language other than English spoken at home, percent age 5+, 2009-2013	20.7%	21.1%
EDUCATION		
High school graduate or higher, percent age 25+, 2009-2013	86.0%	85.2%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	28.8%	31.3%
INCOME		
Per capita money income in past 12 months (2013 dollars), 2009-2013	\$28,155	\$30,469
Median household income, 2009-2013	\$53,046	\$56,361
Persons below poverty level, percent, 2009-2013	15.4%	13.6%
OTHER		
Veterans, 2009-2013	21,263,779	70,621
Persons per square mile, 2010	87.4	1,018.1

(a) Includes persons reporting only one race.

(b) Hispanics may be of any race, so also are included in applicable race categories.

Source: United States Census Bureau, State & County QuickFacts

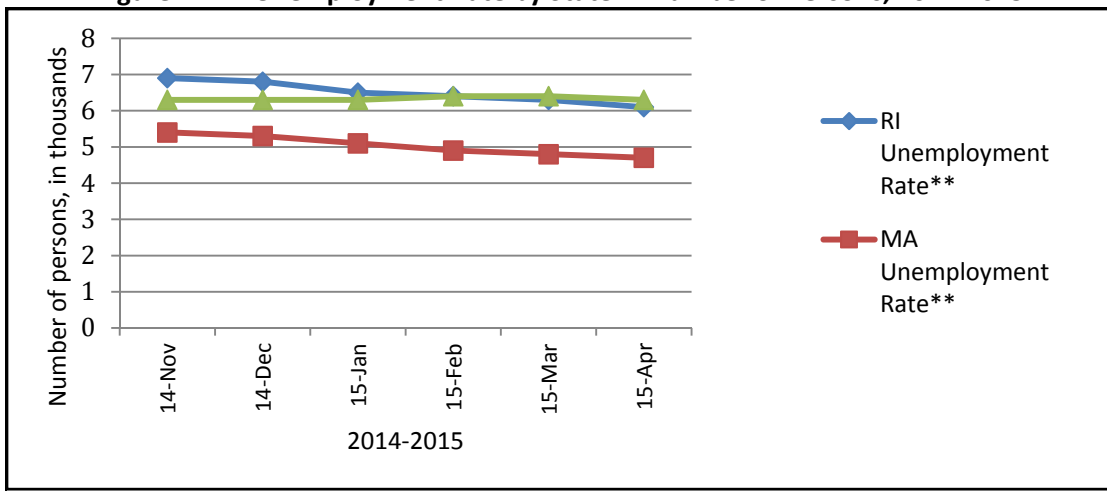
For RI, the number of persons employed has increased from November 2014 to April 2015 (Table 1.4.2). This was accompanied by a decrease in the RI unemployment rate, from 6.9% in November 2014 to 6.1% in April 2015. However, despite these declines, unemployment in RI continues to exceed national levels.

Table 1.4.2. Labor Force Data for RI, MA and CT, 2014-15

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
RI Civilian Labor Force*	549.7	548.8	549	549.6	551.9	553.8
RI Employment*	511.8	511.6	513.1	514.7	517.3	520.1
RI Unemployment*	37.9	37.2	35.9	34.9	34.7	33.7
RI Unemployment Rate**	6.9	6.8	6.5	6.4	6.3	6.1
MA Unemployment Rate**	5.4	5.3	5.1	4.9	4.8	4.7
CT Unemployment Rate**	6.3	6.3	6.3	6.4	6.4	6.3
US Unemployment Rate**	5.6	5.7	5.5	5.5	5.4	5.5

NOTE: *number of persons, in thousands, seasonally adjusted; **in percent, seasonally adjusted
 SOURCE: U.S. Bureau of Labor Statistics (BLS)

Figure 1.4.2. Unemployment Rate by State in Number of Persons, 2014-2015



During and following the recent recession and associated increases in unemployment, the region evidenced increases in homelessness due to bankruptcy among other reasons. Table 1.4.3 presents the population estimates of homelessness for RI, the Northeast and entire US. As shown, the estimated rates of homelessness in RI (0.11%) were lower than the nation (0.19%) and region. This pattern is evident when considering different segments of the population as well - such as homeless families, youth, veterans and the chronically homeless.

Table 1.4.3. RI vs. Region Comparison by Families, Youth, Veterans, and Chronically Homeless; 2014

Estimates of Homeless People By State										
	US	RI	CT	MA	ME	NH	NJ	NY	PA	VT
Homeless	57,8424	1,190	4,450	21,237	2,726	1,376	11,671	80,590	15,333	1,559
2010 Census Population	309,349,689	1,052,567	3,574,097	6,547,629	1,328,361	1,316,470	8,791,894	19,378,102	12,702,379	625,741
% Homeless	0.19%	0.11%	0.12%	0.32%	0.21%	0.10%	0.13%	0.42%	0.12%	0.25%
Estimates of Family Homelessness By State										
Homeless Families	216,261	411	1,381	14,449	1,378	581	5,225	47,947	6,974	736
% Homeless Families	0.07%	0.04%	0.04%	0.22%	0.10%	0.04%	0.06%	0.25%	0.05%	0.12%
Estimates of Homeless Children and Youth By State										
Homeless Children & Youth	194,302	62	194	605	232	94	716	3,790	975	137
% Homeless Youth	0.06%	0.01%	0.01%	0.01%	0.02%	0.01%	0.01%	0.02%	0.01%	0.02%
Estimates of Homeless Veterans By State										
Homeless Veterans	49,933	108	295	1,264	152	171	630	2,542	1,411	120
% Homeless Veterans	0.02%	0.01%	0.01%	0.02%	0.01%	0.01%	0.01%	0.01%	0.01%	0.02%
Estimates of Chronically Homeless Individuals By State										
Chronically Homeless	84,291	204	1,026	1,590	218	301	1,150	4,350	1,449	199
% Chronically Homeless	0.03%	0.02%	0.03%	0.02%	0.02%	0.02%	0.01%	0.02%	0.01%	0.03%

Source: United States Census Bureau, Annual Homeless Assessment Report (AHAR)

Data on health insurance coverage is shown in Table 1.4.4. At 9%, the proportion of the RI population that is uninsured surpasses the entire US (13%) and is comparable to most other states in the region (with the exception of Massachusetts with only 4% uninsured). Compared to the US (48%), RI had a slightly higher percentage of health insurance coverage by employer (50%); but lower than most other states in the region. For Medicaid and Medicare coverage, RI ranks comparable to the US average and other states in the region.

Table 1.4.4. Regional Comparisons of Health Insurance Coverage (%), 2014

	USA	RI	CT	MA	ME	NH	NJ	NY	PA	VT
Uninsured Rate	13	9	9	4	10	11	12	9	10	8
Employer	48	50	56	57	46	56	57	48	54	48
Other Private	6	9	5	7	5	6	4	6	6	6
Medicaid	16	15	14	17	20	10	13	21	13	18
Medicare	15	16	15	14	17	15	13	15	17	19
Other Public	2	1	N/A	N/A	2	1	N/A	1	N/A	2

Source: 2014 Current Population Survey; United States Census Bureau.

Medicaid and Children’s Health Insurance Program (CHIP) commonly provides health coverage to nearly 60 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities (Centers for Medicare and Medicaid Services). Federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups as well (optional eligibility groups) (Centers for Medicare and Medicaid Services).

Brought about by the Affordable Care Act (ACA), many states have expanded coverage of eligibility groups especially for children, well above the federal minimums. Table 1.4.5 summarizes the non-elderly population covered by Medicaid in 2013. The proportion aged 0-18 supported by Medicaid in RI (48%) was lower than the national average (56%), but generally consistent with other states in the region. Regarding the poverty level of those supported with this expanded coverage, RI covered a larger proportion of persons of higher income (under 100% of the federal poverty level) than the region and the overall US.

Table 1.4.5. Nonelderly with Medicaid (%), 2013

	USA	RI	CT	MA	ME	NH	NJ	NY
Age								
0-18	56	48	48	40	44	61	50	43
19-65	44	52	52	60	56	39	50	57
Federal Poverty Level								
Under 100%	41	45	36	38	36	31	40	37
100-199%	31	32	29	32	38	31	26	31
200-399%	19	14	19	19	18	26	26	21
400%+	8	10	16	11	8	12	N/A	11
Race/Ethnicity								
White	41	50	44	51	92	87	42	38
Black	21	N/A	8	13	N/A	N/A	18	20
Hispanic	30	34	43	29	N/A	N/A	34	31
Other	9	7	N/A	N/A	N/A	N/A	N/A	11

Note: N/A indicates estimates with very small sample size.

Source: 2013 Current Population Survey; United States Census Bureau.

2. BODY OF REPORT

2.1. SUBSTANCE USE

Many substance use and consumption questions have been included in state and national surveys of both youth and adults. For adults, the major survey of substance consumption and consequences is the National Survey on Drug Use and Health (NSDUH). Additional indicators, either similar to NSDUH or with alternative wording have been used in surveys of adults, most notably the Behavioral Risk Factor Surveillance System (BRFSS). On the other hand, for youth, major national surveys include the Youth Risk Behavior Surveillance Survey (YRBSS) and the National Survey of Children’s Health (NSCH). See Table A in the appendix for a full listing of data sources. These surveys include questions on a variety of substance use topics (e.g., consumption levels; perceptions of harm) and substance types such as illicit drugs and prescription medications. The following list of substances have been asked and surveyed at both national and state levels.

- Cigarettes
- Smokeless Tobacco
- Other Tobacco
- Marijuana
- Other Substances (Crack, Cocaine, Heroin, Inhalants, Methamphetamines, Ecstasy, Hallucinogenic Drugs, Steroids, Derbisol, Amphilene)
- Prescription drugs / over-the-counter medication
- Generic “illegal drugs”

The current Profile represents some, but not all, of the substances listed above since not all surveys cover all topics for every substance. The following series of Tables (Series 2) present data for RI compared to the US and RI compared to states in the region. Some tables depict time-trends while other tables represent the data by age group and time-trends.

Table 2.1.0 represents RI as compared to the US for any illicit drug use in the past month by age group and over time. From 2007-08 to 2013-14, for all age groups, RI had higher rates of illicit drug use compared to the national average. Despite recent decreases, RI continues to fare worse than the national average for illicit drug use over the past month across all age groups.

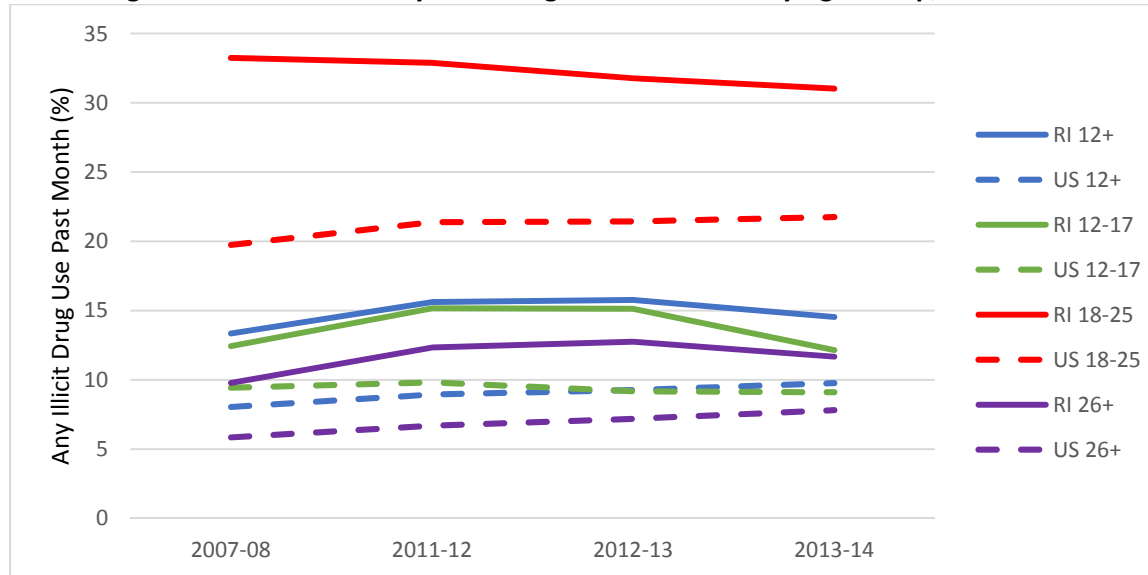
Table 2.1.0. RI vs. US Any Illicit Drug Use Past Month (%) by Age Group, 2007-2014

Age Group	2007-2008				2011-12				2012-13				2013-2014			
	12+	12-17	18-25	26+	12+	12-17	18-25	26+	12+	12-17	18-25	26+	12+	12-17	18-25	26+
RI	13.35	12.43	33.24	9.78	15.61	15.16	32.88	12.33	15.76	15.12	31.77	12.75	14.53	12.14	31.02	11.67
US	8.04	9.43	19.74	5.85	8.95	9.82	21.39	6.69	9.27	9.18	21.44	7.19	9.77	9.11	21.75	7.81
RI/US Ratio	1.66	1.32	1.68	1.67	1.74	1.54	1.54	1.84	1.70	1.65	1.48	1.77	1.49	1.33	1.43	1.49

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: National Survey on Drug Use and Health (NSDUH)

Figure 2.1.0. RI vs. US Any Illicit Drug Use Past Month by Age Group, 2007-2014



Source: National Survey on Drug Use and Health (NSDUH)

Regarding marijuana consumption in the past month, from 2007-08 to 2013-14, RI exceeds the US average across all age groups (e.g. 12+, 12-17, 18-25, and 26+) and across all time periods (Table 2.1.1). For RI and the entire US, for all age groups, there have been increasing levels of monthly marijuana use, but the rates have been increasing more rapidly in RI than the US particularly for adults aged 26+ years. For both the nation and

RI, perceptions of harm of smoking marijuana once a month are decreasing, though RI residents are consistently less concerned about these harms than the national average and those aged 18 to 25 years are the least concerned.

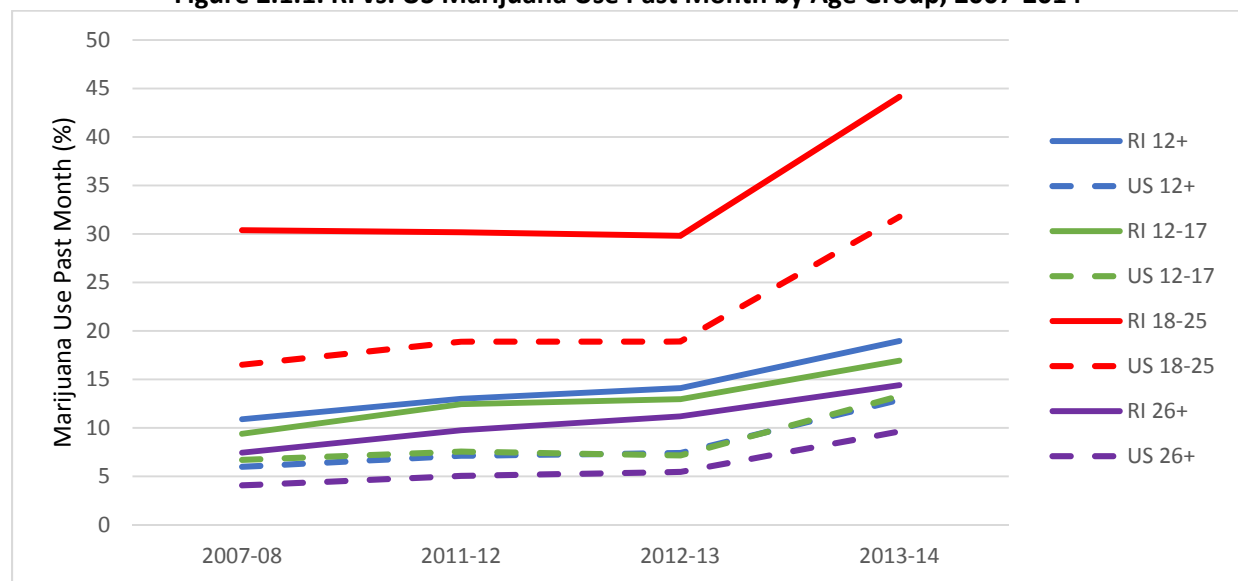
Table 2.1.1. RI vs. US Marijuana Use Past Month (%) by Age Group, 2007-2014

Age Group	2007-08				2011-12				2012-13				2013-2014			
	12+	12-17	18-25	26+	12+	12-17	18-25	26+	12+	12-17	18-25	26+	12+	12-17	18-25	26+
RI	10.88	9.39	30.38	7.44	13.00	12.44	30.16	9.74	14.08	12.95	29.79	11.18	18.95	16.93	44.13	14.40
US	5.98	6.70	16.52	4.07	7.13	7.55	18.89	5.05	7.40	7.15	18.91	5.45	12.90	13.28	31.78	9.63
RI/US Ratio	1.82	1.40	1.84	1.83	1.82	1.65	1.60	1.93	1.90	1.81	1.58	2.05	1.47	1.27	1.39	1.50

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: National Survey on Drug Use and Health (NSDUH)

Figure 2.1.1. RI vs. US Marijuana Use Past Month by Age Group, 2007-2014



Source: National Survey on Drug Use and Health (NSDUH)

Table 2.1.2. RI vs. US Perceptions of Great Risk of Smoking Marijuana Once a Month (%) by Age Group, 2007-2014

Age Group	2007-08				2011-2012				2012-2013				2013-2014			
	12+	12-17	18-25	26+	12+	12-17	18-25	26+	12+	12-17	18-25	26+	12+	12-17	18-25	26+
RI	32.38	29.57	15.91	35.79	23.89	20.08	11.39	26.76	22.18	20.46	10.79	24.59	21.12	18.94	9.06	23.67
US	37.66	33.91	23.69	40.56	31.37	27.02	17.37	34.36	29.50	25.34	15.81	32.40	27.35	23.54	14.22	30.09
RI/US Ratio	0.86	0.87	0.67	0.88	0.76	0.74	0.66	0.78	0.75	0.81	0.68	0.76	0.77	0.80	0.64	0.79

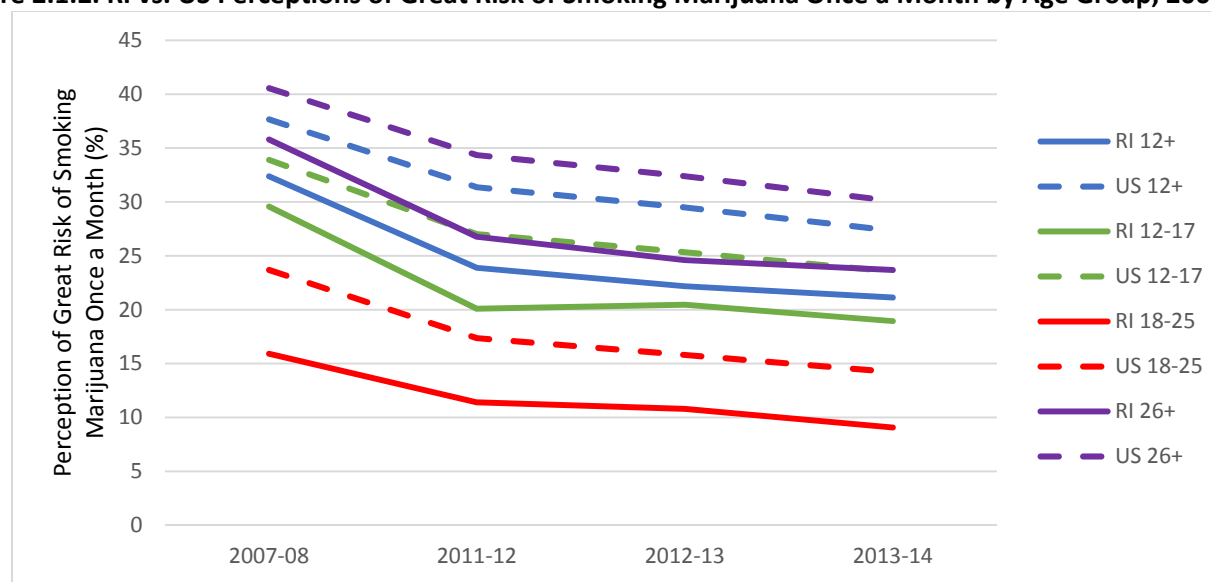
Note: The color scheme for this table has been altered to reflect that a lower perception of great risk is problematic.

Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average.

Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: National Survey on Drug Use and Health (NSDUH)

Figure 2.1.2. RI vs. US Perceptions of Great Risk of Smoking Marijuana Once a Month by Age Group, 2007-2014



Source: National Survey on Drug Use and Health (NSDUH)

In 2007-08 and 2011-12, nonmedical use of pain relievers in the past year was more prevalent in RI among 18-25 year olds relative to national averages. In 2012-13, RI adults aged 26+ had higher rates of nonmedical use of pain relievers in the past year compared to national averages. However, given a steady decline, the most recent data from 2013-14 indicate that RI is consistent with national averages across all age groups for nonmedical use of pain relievers.

Table 2.1.3. RI vs. US Nonmedical Use of Pain Relievers in Past Year by Age Group, 2007-2014

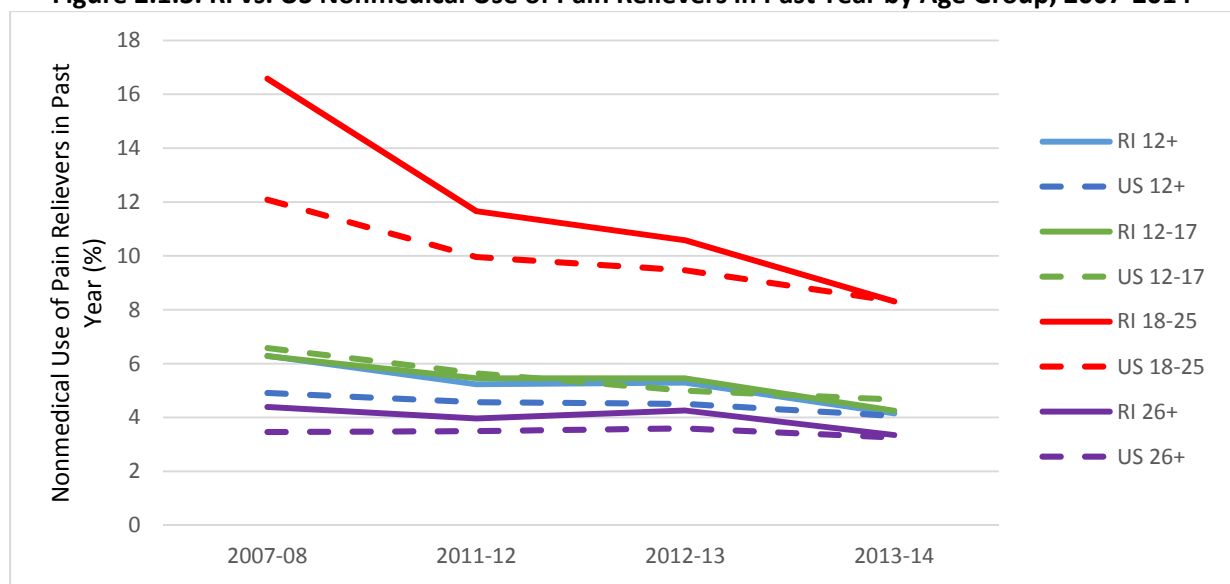
	2007-2008				2011-2012				2012-2013				2013-2014			
Age Group	12+	12-17	18-25	26+	12+	12-17	18-25	26+	12+	12-17	18-25	26+	12+	12-17	18-25	26+
RI	6.29	6.28	16.58	4.39	5.23	5.46	11.66	3.96	5.29	5.45	10.58	4.26	4.15	4.25	8.31	3.35
US	4.91	6.58	12.09	3.46	4.57	5.64	9.96	3.50	4.51	5.00	9.47	3.60	4.06	4.67	8.32	3.26
RI/US Ratio	1.28	0.95	1.37	1.27	1.14	0.97	1.17	1.13	1.17	1.09	1.12	1.18	1.02	0.91	1.00	1.03

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average.

Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: National Survey on Drug Use and Health (NSDUH)

Figure 2.1.3. RI vs. US Nonmedical Use of Pain Relievers in Past Year by Age Group, 2007-2014



Source: National Survey on Drug Use and Health (NSDUH)

RI as compared to the US by age group and across time for DSM-IV drug abuse or dependence (Table 2.1.4) exceeds the US average. For the state of RI, attention to individuals and populations needing but receiving treatment for drug use is important. For most recent estimates in 2013-14, RI exceeds the national average for needing but not receiving treatment for drug use among adults aged 26+ years.

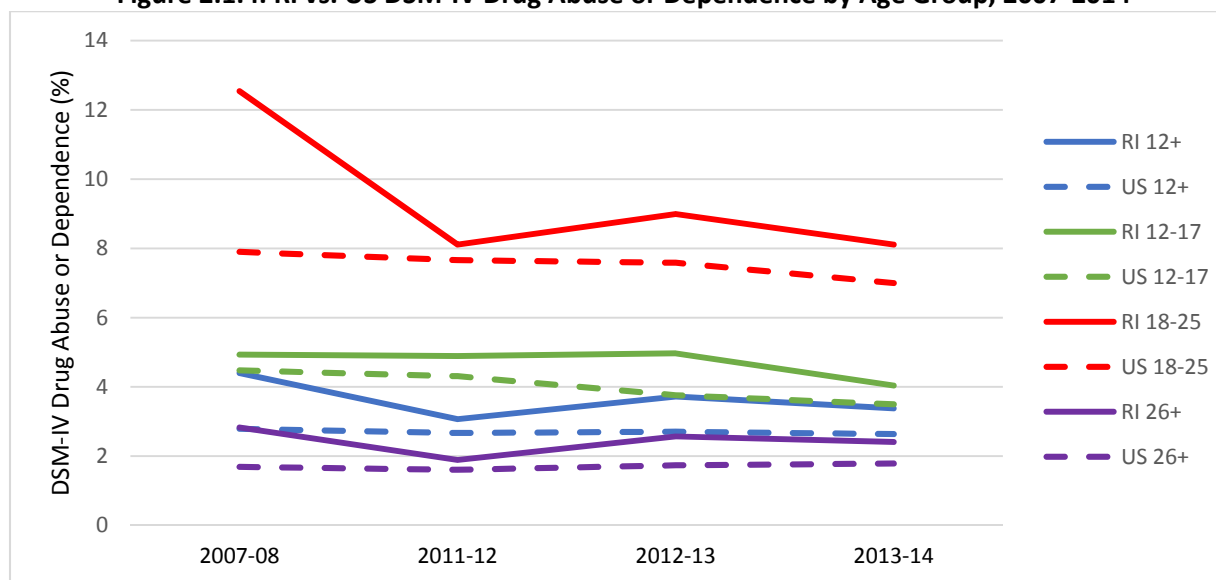
Table 2.1.4. RI vs. US DSM-IV Drug Abuse or Dependence (%) by Age Group, 2007-2014

Age Group	2007-2008				2011-2012				2012-2013				2013-2014					
	12+	12-17	18-25	26+	12+	12-17	18-25	26+	12+	12-17	18-25	26+	18+	12+	12-17	18-25	26+	18+
RI	4.40	4.93	12.54	2.83	3.07	4.89	8.11	1.89	3.72	4.97	8.99	2.57	3.61	3.38	4.04	8.11	2.41	3.31
US	2.79	4.48	7.90	1.69	2.67	4.31	7.66	1.61	2.71	3.76	7.59	1.74	2.60	2.64	3.50	7.00	1.79	2.55
RI/US Ratio	1.58	1.10	1.59	1.67	1.04	1.13	1.06	1.17	1.37	1.32	1.18	1.48	1.39	1.28	1.15	1.16	1.35	1.30

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: National Survey on Drug Use and Health (NSDUH)

Figure 2.1.4. RI vs. US DSM-IV Drug Abuse or Dependence by Age Group, 2007-2014



Source: National Survey on Drug Use and Health (NSDUH)

Table 2.1.5. RI vs. US Needing But Not Receiving Treatment for Drug Use (%) by Age Group, 2007-2014

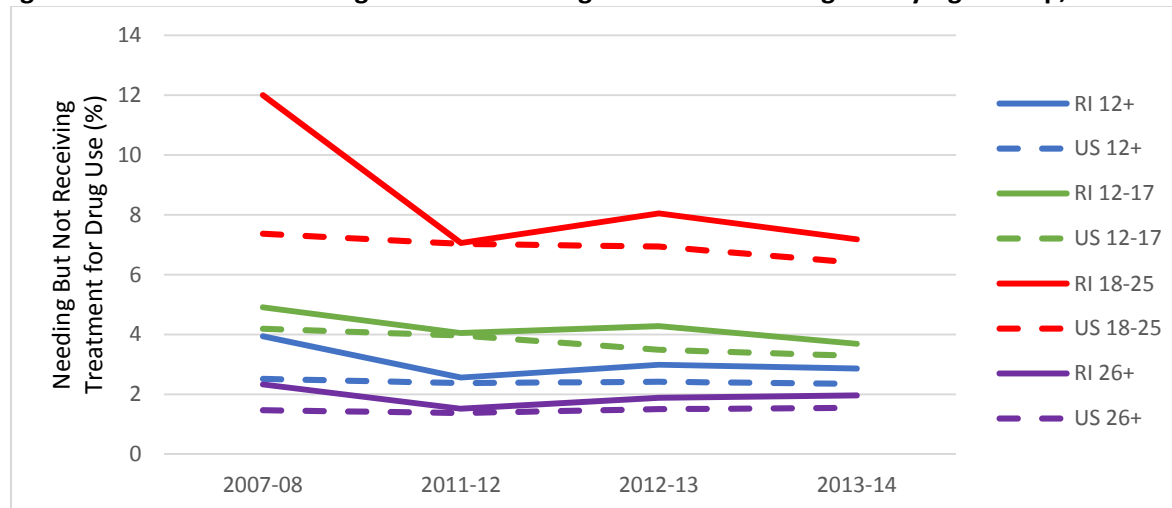
Age Group	2007-2008				2011-2012				2012-2013					2013-2014				
	12+	12-17	18-25	26+	12+	12-17	18-25	26+	12+	12-17	18-25	26+	18+	12+	12-17	18-25	26+	18+
RI	3.94	4.91	12.00	2.33	2.56	4.05	7.06	1.52	2.99	4.28	8.05	1.88	2.87	2.86	3.69	7.18	1.96	2.79
US	2.52	4.19	7.37	1.47	2.38	3.97	7.03	1.38	2.42	3.49	6.94	1.51	2.31	2.35	3.29	6.40	1.55	2.25
RI/US Ratio	1.56	1.17	1.63	1.59	1.08	1.02	1.00	1.10	1.24	1.23	1.16	1.25	1.24	1.22	1.12	1.12	1.26	1.24

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average.

Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: National Survey on Drug Use and Health (NSDUH)

Figure 2.1.5. RI vs. US Needing But Not Receiving Treatment for Drug Use by Age Group, 2007-2014



Source: National Survey on Drug Use and Health (NSDUH)

The total number of RI substance abuse treatment admissions has remained relatively steady from 2012-2014. The gender and race/ethnicity distribution of the admissions has also remained relatively constant. However, there has been a steady increase in treatment admissions for minors (<18) as well as those aged 22 to 30. There has also been a significant increase in treatment admissions for heroin from 20.5% of admissions in 2012 to 31% of admissions in 2014.

Table 2.1.6. Rhode Island Substance Abuse Admissions, 2012-2014

	2012	2013	2014
Total (N)	14015	14783	14406
Gender			
Male	9513 (68%)	10055 (68%)	9741 (68%)
Female	4502 (32%)	4728 (32%)	4665 (32%)
Age Group			
Under 18	52 (0.5%)	140 (1%)	398 (3%)
18-21	643 (5%)	684 (5%)	878 (6%)
22-30	3142 (22.5%)	3781 (25%)	3982 (27%)
31-45	5614 (40%)	5777 (39%)	5303 (37%)
45-65	4381 (31%)	4244 (29%)	3738 (26%)
Over 65	183 (1%)	157 (1%)	107 (1%)
Race/Ethnicity			
Native American	180 (1%)	159 (1%)	141 (1%)
Asian	77 (0.5%)	79 (0.5%)	80 (0.5%)
Black	1071 (8%)	1010 (7%)	977 (7%)
Hawaiian/Pacific Islander	40 (0.5%)	75 (0.5%)	60 (0.5%)
Hispanic	1158 (8%)	1100 (7%)	953 (7%)
Unknown	515 (4%)	526 (4%)	644 (4%)
White	10974 (78%)	11834 (80%)	11551 (80%)
Primary Substance			
Alcohol	5536 (39.5%)	5699 (39%)	5292 (37%)
Cocaine	1140 (8%)	1107 (7.5%)	1095 (7.5%)
Marijuana	1680 (12%)	1550 (10.5%)	1296 (9%)
Heroin	2875 (20.5%)	3649 (25%)	4431 (31%)
Other	2784 (20%)	2778 (19%)	2292 (16%)

NOTE: These data reflect number of treatment admissions, not number of people as there may be multiple admissions for the same person during a calendar year.

Source: Rhode Island Behavioral Health On-Line Data Service (BHOLD)

Assessing substance consumption and identifying patterns for various populations is extremely important for the optimal development of programs for prevention and treatment. High school students are a vulnerable population because children and youth are still developing physically and mentally. Substance consumption can be linked to both short term and long-term adverse health outcomes and consequences. From 2001-2013, the RI high school student population had lower rates of cigarette, tobacco, initial use of marijuana, and prescription drug misuse than the US average rates. The use of marijuana in the past month for RI high school students is decreasing over time, although RI still exceeds the US average (Table 2.1.7). These data may seem inconsistent with previously reported rates of past month marijuana use (e.g. NSDUH data Table 2.1.1), both in magnitude and relative to the national average. However, YRBS data presented are specifically representative of high school students who tend to be between the ages of 14 and 18 years, while the most similar data measurement from NSDUH is among youth aged 12-17 years. The discrepancy may be due to either the difference in age group or differences in the data collection method.

Table 2.1.7. RI vs. US Substance Consumption for High School Students, 2001-2015

% of Students (grades 9-12) Reporting:	2001			2009			2011			2013			2015
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI
Cigarette Use													
Smoking cigarettes 20+ days past month	14.2	13.8	1.03	5.4	7.3	0.74	4.4	6.4	0.69	3.1	5.6	0.55	--
Initial use of tobacco before age 13	22.3	22.1	1.01	8.4	10.7	0.79	7.1	10.3	0.69	5.6	9.3	0.60	--
Marijuana Use													
Using marijuana past month	33.2	23.9	1.39	26.3	20.8	1.26	26.3	21.3	1.23	23.9	23.4	1.02	23.6
Initial use of marijuana before age 13	12.8	10.2	1.25	8.3	7.5	1.11	7.1	8.1	0.88	6.8	8.6	0.79	--
Prescription Drug Use													
Prescription drug misuse past year	--	--	--	--	--	--	14.1	20.7	0.68	13.5	17.8	0.76	11.6

Note Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: Youth Risk Behavior Surveillance Survey (YRBSS)

Table 2.1.8 presents RI as compared to other states in the region for lifetime consumption of various substances among high school students. RI shows lower prevalence than the national averages for most indicators shown. Ever use of heroin among the RI high school student population stands out as an area warranting greater attention, preventive and therapeutic efforts.

In 2013, the RI high school population had a smaller prevalence of “ever marijuana use” than the US and an overall downward trend from 2003 to 2013 (Table 2.1.8). In that same time period, a downward trend of initial marijuana use before age 13 occurred. Although the use of marijuana in the past month exceeds the national average, the RI underage population had a downward trend from 2001 to 2013 (Table 2.1.9). An examination of program and policies regarding possession and access to marijuana for this particular population may be useful to determine which components may be affecting the use of marijuana.

Table 2.1.8. RI vs. Region Lifetime Consumption of Various Substances for High School Students (%), 2003-2015

	USA	RI	CT	MA	ME	NH	NJ	NY	PA	VT
Ever cigarette use										
2009	46.3	39.4	--	43.3	--	--	42.8	37.2	45.1	--
2011	44.7	35.0	--	38.5	--	--	40.6	33.5	--	--
2013	41.1	29.7	--	31.6	32.1	--	34.2	30.9	--	--
2015	--	22.4	--	--	--	--	--	--	--	--
Ever marijuana use										
2009	36.8	39.9	37.6	42.5	36.2	40.5	35.3	34.7	35.0	--
2011	39.9	40.1	39.6	43.1	35.8	--	36.9	--	--	--
2013	40.7	39.5	42.1	41.3	--	--	38.9	--	--	--
2015	--	38.7	--	--	--	--	--	--	--	--
Ever cocaine use										
2009	6.4	5.4	5.4	6.1	--	6.5	5.7	7.2	5.5	--
2011	6.8	5.9	5.0	5.0	--	8.4	4.4	6.2	--	--
2013	5.5	4.5	4.9	3.7	--	4.9	4.8	5.3	--	6.3
2015	--	4.8	--	--	--	--	--	--	--	--
Ever inhalant use										
2009	11.7	8.7	10.6	--	14.8	11.9	9.7	10.8	10.3	--
Ever ecstasy use										
2003	11.1	8.9	--	9.1	9.6	10.3	--	6.1	--	--
2005	6.3	6.0	6.4	--	5.3	5.5	5.0	4.1	--	--
2007	5.8	6.6	6.6	--	--	6.4	--	6.1	--	--
2009	6.7	5.9	5.0	5.9	--	6.8	5.0	5.8	5.1	--
Ever used heroin										
2003	3.3	3.5	--	3.0	3.3	2.3	--	1.8	--	3.2
2005	2.4	3.7	4.3	2.4	3.5	2.1	1.4	1.8	--	3.1
Ever used methamphetamines										
2003	7.6	6.9	--	6.1	8.3	7.4	--	4.7	--	7.2
2005	6.2	6.0	5.9	4.4	5.2	5.5	2.6	3.3	--	5.6
2013	3.2	3.3	4.3	1.6	--	2.9	2.6	4.5	--	3.6

Note: RI Indicators greater than national averages are shown in red. RI indicators less than national averages are shown in green.

Source: Youth Risk Behavior Surveillance System (YRBSS)

Lower prevalence of prescription drug use among youth in RI as compared to the US were observed (Table 2.1.9). New to this Profile is the examination of substance use by racial groups of high school students (Table 2.1.10). RI is predominantly white and for this population, marijuana use exceeds the national average. Additionally Asian high school students also had a larger rate compared to the national average. For the Hispanic high school student population in RI, use of methamphetamines was larger than the national average. Compared to US averages, the racial/ethnic group in RI at most risk of various substance uses is Black high school students. Among African-American students, RI rates exceed the national average for ever used cocaine and ever used methamphetamines. The RI value for ever cocaine use was 7.4% in RI compared to 2.1% for the US, and methamphetamines the proportions were 7.7% and 1.3%, respectively.

Table 2.1.9. RI vs. Region Marijuana and Prescription Drug Consumption for High School Students, 2001-2015

	USA	RI	CT	MA	ME	NH	NJ	NY	PA	VT
% Using marijuana past month										
2001	23.9	33.2	--	30.9	27.2	--	24.9	--	--	30.3
2009	20.8	26.3	21.8	27.1	20.5	25.6	20.3	20.9	19.3	24.6
2011	23.1	26.3	24.1	27.9	21.2	28.4	21.1	20.5	--	24.4
2013	23.4	23.9	26	24.8	21.3	24.4	21	21.4	--	25.7
2015	--	23.6	--	--	--	--	--	--	--	--
% Initial use of marijuana before age 13										
2001	10.2	12.8	--	11.9	12	--	9.2	--	--	12.2
2009	7.5	8.3	5.8	9	9.8	8.4	4.1	7.7	5.3	8.7
2011	8.1	7.1	6.3	6.9	7.3	7.7	4.3	7.6	--	6.4
2013	8.6	6.8	7	6.6	7.1	6.6	5.1	7.3	--	8.4
% Ever took prescription drugs without a doctor's prescription										
2011	20.7	14.1	--	--	13.9	20.8	15.1	--	--	--
2013	17.8	13.5	--	--	12.4	16.5	11.8	--	--	--
2015	--	11.6	--	--	--	--	--	--	--	--

Note: RI Indicators greater than national averages are shown in red. RI indicators less than national averages are shown in green.

Source: Youth Risk Behavior Surveillance System (YRBSS)

Examining substance use by racial sub-groups has the potential to identify segments and regions of the population warranting targeted prevention and treatment efforts. After identification of high risk sub-groups, further work should be done to assess whether their needs are best addressed by culturally specific or culturally sensitive interventions or practices. Further analysis and clinical review of exposure to and use of various substances by subgroups in RI will be important to create programs and policies to address different needs within the state.

Table 2.1.10. Racial/Ethnic Disparities in High School Substance Use, 2013

	Asian	Black	Hispanic	White	Multiple Race
	Current Cigarette Use				
RI	--	5.3	4	9.4	11.8
US	10.3	8.3	14	18.6	14.2
RI/US Ratio	--	0.64	0.29	0.51	0.83
	Current Alcohol Use				
RI	--	33.7	30.9	31.4	17.3
US	21.7	29.6	37.5	36.3	36.1
RI/US Ratio	--	1.14	0.82	0.87	0.48
	Current Marijuana Use				
RI	23.4	25.8	24.7	23.6	19.8
US	16.4	28.9	27.6	20.4	28.8
RI/US Ratio	1.43	0.89	0.89	1.16	0.69
	Ever Prescription Drug Abuse				
RI	3.8	14.4	10.5	14.2	14
US	11.8	13.3	19.2	18.7	19.1
RI/US Ratio	0.32	1.08	0.55	0.76	0.73
	Ever Used Cocaine				
RI	2.3	7.4	5.3	3.4	3.5
US	5.3	2.1	9.5	4.8	6.1
RI/US Ratio	0.43	3.52	0.56	0.71	0.57
	Ever Used Methamphetamines				
RI	0.9	7.7	5.1	1.8	0
US	3.8	1.3	4.5	3	3.5
RI/US Ratio	0.24	5.92	1.13	0.60	0.00

NOTE: American Indian or Alaskan Native and Native Hawaiian or other Pacific Islander were excluded due to small sample size in RI. Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: Youth Risk Behavior Surveillance System (YRBSS)

SUMMARY

RI as compared to the US by age groups across time fare worse with higher prevalence rates for illicit drug use in the past month, marijuana use in the past month, and DSM-IV drug abuse or dependence. Needing but not receiving treatment for drug abuse/dependence is a problem in RI for adults aged 26+. Also, RI substance abuse admissions for heroin are growing rapidly over the past few years. Furthermore, Rhode Islanders perceive the risk of smoking marijuana once a month lower than the national average. When focusing on the high school student population, RI does better with lower than the national average for smoking cigarettes, use of tobacco before age 13, and prescription drug misuse in the past year.

Additionally, when reporting by racial or ethnic disparities in high school youth, RI black high school students were at a higher risk for use of alcohol, prescription drug abuse, cocaine, and methamphetamines.

2.2 ALCOHOL CONSUMPTION

Data on alcohol consumption are more readily available than data for other substances. Table 2.2.0 presents RI versus US comparison of alcohol use in the past month by age group and across time. Across all age groups (e.g. 12+, 12-17, 18-25, and 26+) for all time points before 2013-14 (e.g. 2007-08, 2011-12, 2012-13), alcohol consumption patterns in RI exceeded the US average. However, following general increases from 2007 – 2011 alcohol use in the past month for Rhode Islanders of all ages decreased by 2012-13 and were very similar in 2013-14 compared to US values.

DSM-IV alcohol abuse or dependence by age group and time depicted a downward trend nationally (Table 2.2.1). Regardless, RI adults 18+ still exceeded the US in prevalence of alcohol abuse or dependence. Most recent data show that RI adults aged 18-25 years continue to have a higher prevalence as compared to the nation.

Figure 2.2.1 depicts the trends of RI versus US for prevalence of DSM-IV alcohol abuse or dependence by age group. This graphic shows that both in RI and for the entire US, persons aged 18-25 had the highest prevalence of alcohol abuse or dependence over time, indicating that this age group is at a higher risk. Work in alcohol prevention and treatment should target 18-25 years of age, in particular college- and university-based programming.

Treatment for alcohol use is also needed. RI as compared to the US had larger prevalence over time for all age groups (e.g. 12+, 12-17, 18-25, 26+ and 18+) of needing but not receiving treatment for alcohol use. For the 18-25 age group, this prevalence remains highest relative to the national average. Continued work needs to be done here, particularly among those aged 18-25 years.

Similar to Figure 2.2.1, Figure 2.2.2 shows that in both RI and the entire US, the 18-25 age group had the highest prevalence for needing but not receiving treatment for alcohol use. This is consistent with the DSM-IV alcohol abuse or dependence (Figure 2.2.1). Therefore, this high risk population should be the target group for alcohol-related prevention and programming.

Table 2.2.0. RI vs. US Comparison Alcohol Use Past Month (%) by Age Group, 2007-2014

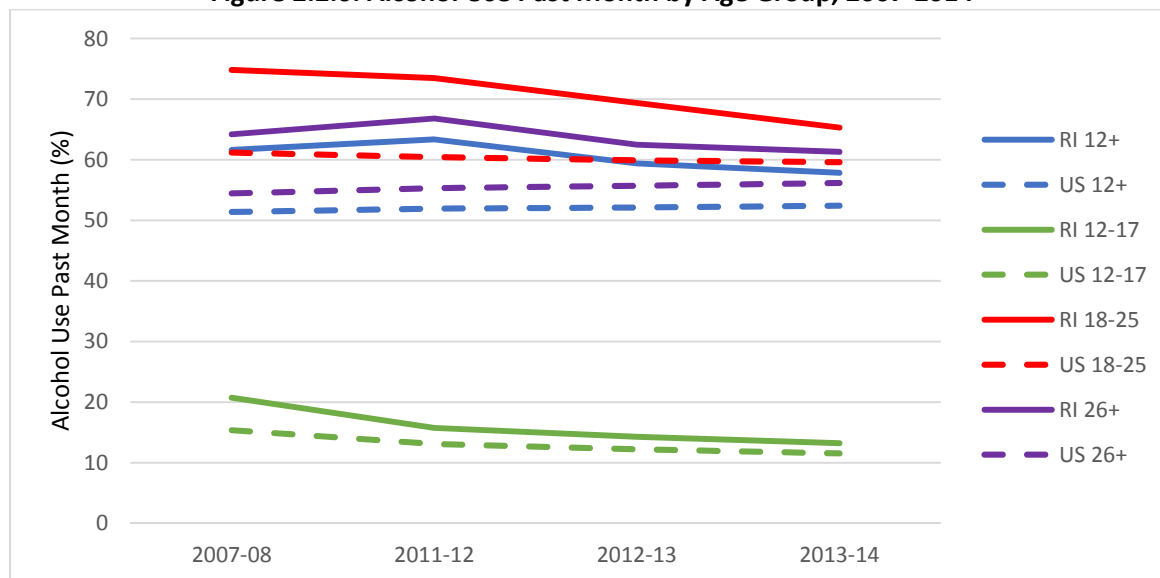
	2007-2008				2011-2012				2012-2013				2013-2014			
Age Group	12+	12-17	18-25	26+	12+	12-17	18-25	26+	12+	12-17	18-25	26+	12+	12-17	18-25	26+
RI	61.62	20.74	74.80	64.19	63.35	15.74	73.46	66.80	59.38	14.27	69.37	62.48	57.82	13.21	65.30	61.28
US	51.39	15.38	61.18	54.44	51.94	13.11	60.45	55.33	52.13	12.23	59.91	55.73	52.42	11.55	59.60	56.18
RI/US Ratio	1.20	1.35	1.22	1.18	1.22	1.20	1.22	1.21	1.14	1.17	1.16	1.12	1.10	1.14	1.10	1.09

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average.

Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: National Survey on Drug Use and Health (NSDUH)

Figure 2.2.0. Alcohol Use Past Month by Age Group, 2007-2014



Source: National Survey on Drug Use and Health (NSDUH)

Table 2.2.1. RI vs. US DSM-IV Alcohol Abuse or Dependence (%) by Age Group, 2007-2014

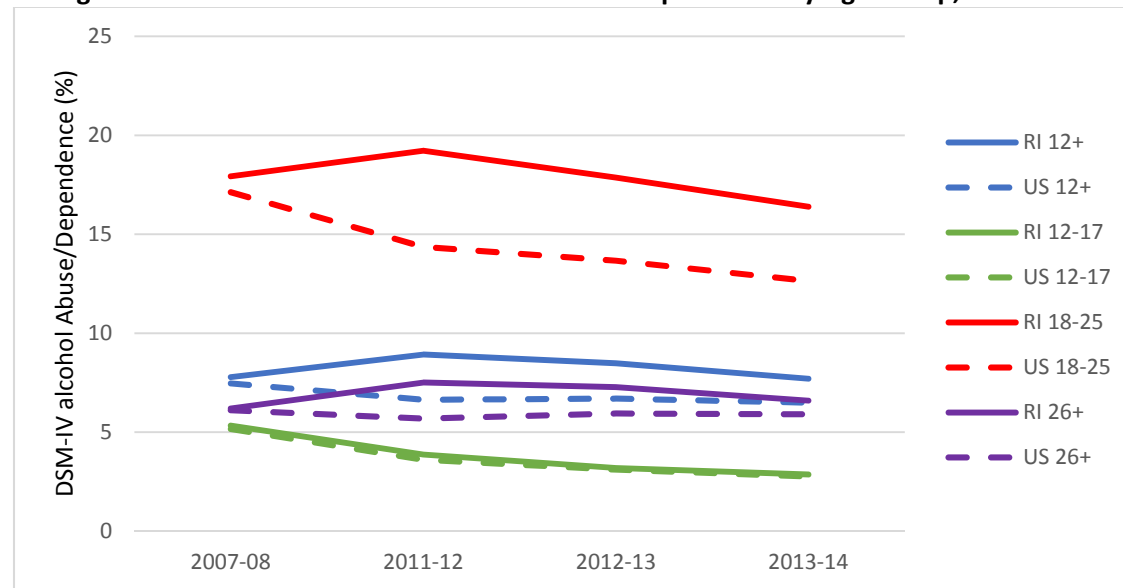
Age Group	2007-2008				2011-2012				2012-2013					2013-2014				
	12+	12-17	18-25	26+	12+	12-17	18-25	26+	12+	12-17	18-25	26+	18+	12+	12-17	18-25	26+	18+
RI	7.78	5.33	17.93	6.2	8.92	3.87	19.22	7.51	8.48	3.19	17.86	7.27	8.97	7.70	2.86	16.39	6.59	8.15
US	7.47	5.16	17.13	6.11	6.64	3.61	14.36	5.69	6.70	3.11	13.67	5.95	7.08	6.50	2.76	12.64	5.91	6.89
RI/US Ratio	1.04	1.03	1.05	1.01	1.33	1.07	1.34	1.32	1.27	1.03	1.31	1.22	1.27	1.18	1.04	1.30	1.12	1.18

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average.

Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: National Survey on Drug Use and Health (NSDUH)

Figure 2.2.1. RI vs US DSM-IV Alcohol Abuse or Dependence by Age Group, 2007-2013



Source: National Survey on Drug Use and Health (NSDUH)

Table 2.2.2. RI vs. US Needing But Not Receiving Treatment for Alcohol Use (%) by Age Group, 2007-2014

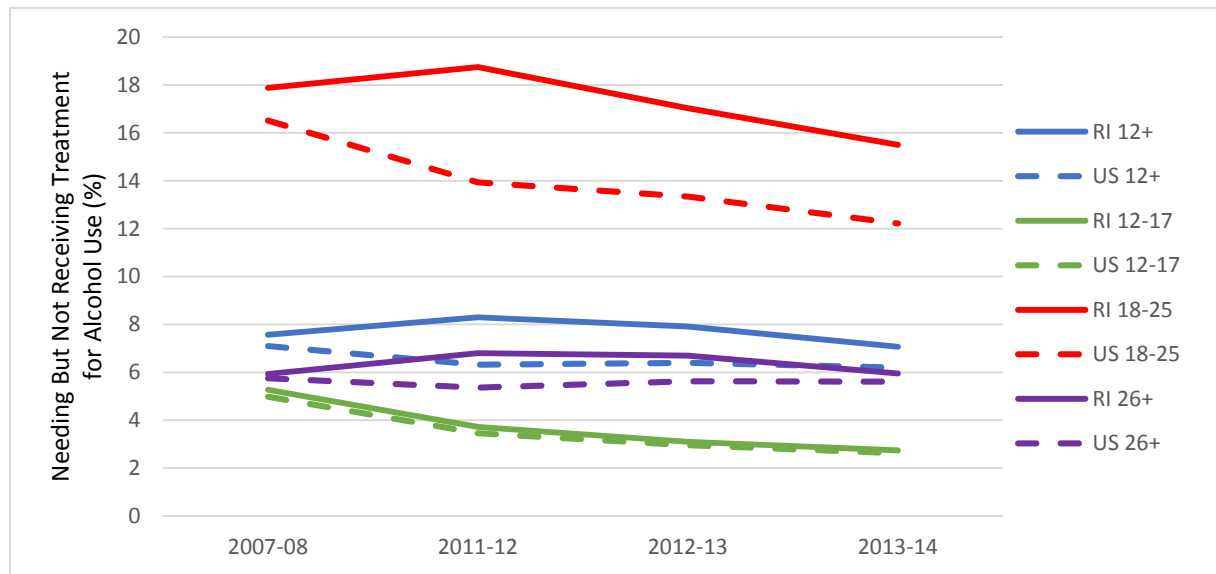
Age Group	2007-08				2011-12				2012-2013					2013-2014				
	12+	12-17	18-25	26+	12+	12-17	18-25	26+	12+	12-17	18-25	26+	18+	12+	12-17	18-25	26+	18+
RI	7.57	5.27	17.88	5.93	8.30	3.72	18.75	6.80	7.91	3.10	17.03	6.69	8.36	7.07	2.74	15.50	5.95	7.47
US	7.10	4.98	16.52	5.75	6.32	3.46	13.94	5.36	6.40	2.96	13.34	5.63	6.76	6.20	2.62	12.22	5.61	6.57
RI/US Ratio	1.07	1.06	1.08	1.03	1.31	1.08	1.35	1.27	1.24	1.05	1.28	1.19	1.24	1.14	1.05	1.27	1.06	1.14

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average.

Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: National Survey on Drug Use and Health (NSDUH)

Figure 2.2.2. RI vs. US Needing But Not Receiving Treatment for Alcohol Use by Age Group, 2007-2014



Source: National Survey on Drug Use and Health (NSDUH)

Alcohol consumption for the high school students in RI as compared to the US had lower prevalence rates over time (Table 2.2.3). These data may seem inconsistent with previously reported rates of past month marijuana use (e.g. NSDUH data Table 2.2.0), both in magnitude and relative to the national average. However, YRBS data presented are specifically representative of high school students who tend to be between the ages of 14 and 18 years, while the most similar data measurement from NSDUH is among youth aged 12-17 years. The discrepancy may be due to either the difference in age group or differences in the data collection method.

After several years of decline (2001 – 2011), prevalence of drinking and driving in the past month increased from 2011 – 2013 for both RI and US. The prevalence rates for underage alcohol consumption suggest that efforts around prevention, intervention, and treatment may have contributed to reduce alcohol use in the past month and binge drinking in the past month. However, work around alcohol consumption especially having been in a car with a driver who had been drinking remains problematic with 20.1% of the high school student population reported having had this experience.

Table 2.2.3. RI vs. Region Alcohol Consumption for High School Students, 2001-2015

% of Students (grades 9-12) Reporting:	2001			2009			2011			2013			2015
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI
Alcohol Use													
Alcohol use past month	50.3	47.0	1.07	34.0	41.8	0.81	30.0	38.7	0.78	30.9	34.9	0.89	26.1
Binge drinking past month	30.7	29.9	1.03	18.7	24.2	0.77	18.3	21.9	0.84	15.3	20.8	0.74	12.8
Initial use of alcohol before age 13	29.7	29.1	1.02	15.8	21.1	0.75	15.6	20.5	0.76	13.5	18.6	0.73	--
Drinking and driving past month	15.5	13.3	1.17	7.2	9.7	0.74	6.5	8.2	0.79	8.5	10.0	0.85	--
In car w/ driver who had been drinking (past month)	32.3	30.7	1.05	23.1	28.3	0.82	21.9	24.1	0.91	20.1	21.9	0.92	--

Note Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: Youth Risk Behavior Surveillance System (YRBSS)

When comparing regional alcohol consumption for the underage population (Table 2.2.4) in 2013, Rhode Islanders had lower rates of consumption than Connecticut, Massachusetts, New Hampshire, New Jersey, New York, and Vermont. The initial use of alcohol before age 13 and percentage reporting drinking and driving in the past month for Rhode Islanders are similar to comparison states.

Table 2.2.4. RI vs. Region Alcohol Consumption among High School Students, 2001-2015

	USA	RI	CT	MA	ME	NH	NJ	NY	PA	VT
Ever had at least one drink of alcohol										
2001	78.2	78.8	--	81.2	--	--	83.4	--	--	--
2009	72.5	63.9	--	71.3	65.2	68.5	74.6	--	70.5	--
2011	70.8	62.0	--	67.5	59.0	67.1	69.1	--	--	--
% Binge drinking (5+ drinks in one sitting) past month										
2001	29.9	30.7	--	32.7	31.5	--	32.6	--	--	29
2009	24.2	18.7	24.2	24.5	--	24	26.7	23.8	21.9	23.1
2011	21.9	18.3	22.3	22.2	16.2	23.8	23.7	22	--	20.9
2013	20.8	15.3	20	18.9	14.4	17.3	23	18.4	--	21.4
2015	--	12.8	--	--	--	--	--	--	--	--
% Initial use of alcohol before age 13										
2001	29.1	29.7	--	27.9	21.7	--	32.5	--	--	26
2009	21.1	15.8	17.6	17.2	20.3	14.8	18	21	19	18.2
2011	20.5	15.6	15.6	14.6	15.8	14.3	14.4	19	--	14.8
2013	18.6	13.5	14.9	--	13.3	11.9	14.6	--	--	16.2
% Drinking and driving past month										
2001	13.3	15.5	--	12.2	10.8	--	13	--	--	10.1
2009	9.7	7.2	8.7	9	--	8.5	7.7	10	6.9	8
2011	8.2	6.5	6.9	6.5	--	8.6	6.4	5.4	--	7.1
2013	10	8.5	9.4	7.1	6.6	8.4	8.7	10.2	--	10.2

Note: RI Indicators greater than national averages are shown in red. RI indicators less than national averages are shown in green.

Source: Youth Risk Behavior Surveillance System (YRBSS)

For the first time, this Profile takes into account racial and ethnic disparities in alcohol use (Table 2.2.5). In 2013, 33.7% of high school students in RI who self-identified as Black reported current alcohol use when compared to Hispanic (30.9%), White (31.4%), and multiple races (17.3%). Accordingly, in RI, Black high school students had the highest prevalence of alcohol use. In contrast, for the US as a whole, Black high school students report the lowest (29.6%) rates of alcohol use compared to other races.

Table 2.2.5. Racial/Ethnic Disparities in High School Alcohol Use, 2013

	Asian	Black	Hispanic	White	Multiple Race
Current Alcohol Use					
RI	--	33.7	30.9	31.4	17.3
US	21.7	29.6	37.5	36.3	36.1
RI/US Ratio	--	1.14	0.82	0.87	0.48

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: Youth Risk Behavior Surveillance System (YRBSS)

SUMMARY

Alcohol consumption across all age groups in RI exceeded US values. In particular, the 18-25 age group was at the most risk for alcohol consumption in the past month, alcohol abuse or dependence, and needing but not receiving treatment for alcohol use. Additionally, alcohol consumption for high school students had lower prevalence in RI as compared to the US in the past three data collection points (2009, 2011, and 2013). When alcohol consumption for high school students were compared regionally, RI high school students were lower in prevalence compared to other regional states for ever had at least one drink of alcohol and binge drinking in the past month.

2.3 MENTAL HEALTH

Mental health is often stigmatized and especially for children, diagnosis and treatment vary. Table 2.3.0 shows children age 2-17 and children 8-17 with special health care needs and the services they may or may not have received by regional comparison. In 2007 and 2009-10, RI exceeded the US average for children age 2-17 who needed and received mental health services. RI as compared to US and neighboring states, MA and CT, had a higher percentage of children age 2-17 that needed and received mental health services in 2011-12.

In 2009-10, 97.8% of RI children 8-17 did not need substance abuse treatment (Table 2.3.0). Of the remaining children who needed substance abuse treatment, 1.8% of RI children 8-17 received all needed treatment, leaving 0.4% of RI children with unmet needs. RI (83.1%) exceeds the US average (76.6%) of providing all treatment to those children 8-17 who needed substance abuse treatment.

Table 2.3.0. Child Health Indicators among Children with Special Health Care Needs (%)				
	US	RI	MA	CT
Children age 2-17				
Needed but did not get mental health services (2007)	40	24	33.4	21.2
Needed and received mental health services (2007)	60	76	66.6	78.8
CSHCN who did not need mental health care (2009/10)	72.4	68.5	66.1	70.2
CSHCN who received needed mental health care (2009/10)	21.9	26.8	29	25
CSHCN with unmet mental health care needs (2009/10)	5.6	4.7	4.9	4.8
Needed but did not get mental health services (2011/12)	39	34	35.1	35
Needed and received mental health services (2011/12)	61	66	64.9	65
Children age 8-17				
Did not need substance abuse treatment (2009/10)	97.3	97.8	97.4	98.5
Received needed substance abuse treatment (2009/10)	2	1.8	1.9	1.4
Needed but did not get substance abuse treatment (2009/10)	0.6	0.4	0.7	0.2
Needed and received all substance abuse treatment (2009/10)	76.6	83.1	73	89
Needed and received some substance abuse treatment (2009/10)	11.2	7.3	27	0
Needed and did not receive substance abuse treatment (2009/10)	12.2	9.7	0	11

NOTE: Children with special health care needs are defined in the National Survey of Children's Health as those who have chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Source: National Survey of Children's Health (NSCH)

Children with special health care needs receive varying care and treatment for emotional and mental health issues as well as health care access and quality (Table 2.3.1). In RI among children with special health care needs, 64.7% of children age 4 months to 5 years have physical, behavioral or social development issues that are of concern to their parents, compared to the US average (60.2%). Supporting these data, in 2007, 32.0% of RI children age 4 months to 5 years were at high risk for developmental, behavioral, or social delay. The national average was 23.9% and the values for neighboring states, MA and CT were 27.1% and 21.2%, respectively.

Also in 2007, 21.2% of RI children age 6-17 were identified to often exhibit problematic social behaviors as compared to 17.9% nationally, 16.4% for MA children, and 13.8% for CT children (Table 2.3.1). RI children had higher rates of problematic social behavior but also had higher rates of current ADHD or ADD and treatment by medication. RI had almost 7% percentage points more than then the US, MA, and CT values. Additionally, RI ranks over 10% more percentage points than US, MA, and CT for children age 2-17 who currently have moderate or severe ADHD or ADD in 2007. This trend was also similar for these children to also be on medications because of difficulties with emotions, concentration or behaviors.

Health care access and quality is an important indicator whether children are receiving the care and treatment they need. Among children age 10 months to 5 years who had health care in the past 12 months, those who had a health care visit that included developmental screenings varied. 20.0% of RI

children were screened as compared to the national average of 23.9%. MA fares better with 33.8% of their children had received developmental screenings while CT fares worse with 8.1% of their children age 10 months to 5 years.

Table 2.3.1. Child Health Indicators among Children with Special Health Care Needs (%)				
	US	RI	MA	CT
Emotional and Mental Health				
Children age 4 months to 5 years whose physical, behavioral or social development is of concern to their parents	60.2	64.7	63.2	50.5
Children age 4 months to 5 years who are at high risk for developmental, behavioral or social delay	23.9	32.0	27.1	21.2
Children age 6-17 who often exhibit problematic social behaviors	17.9	21.2	16.4	13.8
Children age 2-17 who currently have ADHD or ADD and are taking medications for it	19.2	27.4	20.9	14.3
Children age 2-17 who currently have moderate or severe ADHD or ADD	15.0	25.9	15.0	13.4
Children age 2-17 who currently take medication because of difficulties with emotions, concentration or behavior	26.4	35.0	30.4	22.3
Health Care Access and Quality				
Among children age 10 months to 5 years who had health care in the past 12 months, those who had a health care visit that included developmental screening	23.9	20.0	33.8	8.1

NOTE: Children with special health care needs are defined in the National Survey of Children's Health as those who have chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Source: 2007 National Survey of Children's Health

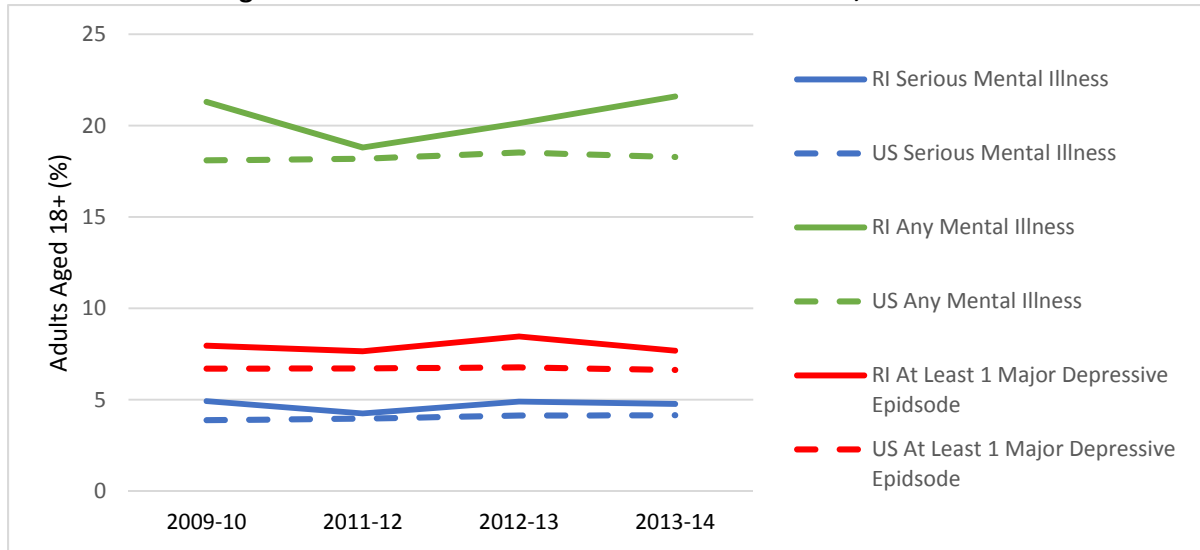
RI fares worse than the national average for all adult mental health indicators in 2013-2014, including serious mental illness, any mental illness, and having had at least one major depressive episode in the past year (Table 2.3.2). Adults aged 26 or more years contributed more to this rate than adults aged 18-25 years (Figure 2.3.2).

Table 2.3.2. RI vs. US Adult Mental Health Indicators, 2009-2014

Age Group	18+			18-25			26+		
Serious Mental Illness in the Past Year (%)									
	RI	US	RI/US Ratio	RI	US	RI/US Ratio	RI	US	RI/US Ratio
2009-2010	4.92	3.88	1.27	4.38	3.63	1.21	5.02	3.92	1.28
2011-2012	4.25	3.97	1.07	4.27	3.95	1.08	4.25	3.98	1.07
2012-2013	4.9	4.14	1.18	4.47	4.17	1.07	4.99	4.14	1.21
2013-2014	4.77	4.15	1.15	4.79	4.52	1.06	4.76	4.09	1.16
Any Mental Illness in the Past Year (%)									
2009-2010	21.3	18.1	1.18	19.42	18.02	1.08	21.65	18.11	1.20
2011-2012	18.8	18.19	1.03	18.8	19.06	0.99	18.81	18.04	1.04
2012-2013	20.13	18.53	1.09	19.93	19.5	1.02	20.17	18.36	1.10
2013-2014	21.6	18.29	1.18	21.09	19.75	1.07	21.70	18.05	1.20
Had at Least One Major Depressive Episode in the Past Year (%)									
2009-2010	7.95	6.7	1.19	9.33	8.15	1.14	7.69	6.45	1.19
2011-2012	7.65	6.72	1.14	8.79	8.61	1.02	7.43	6.39	1.16
2012-2013	8.46	6.77	1.25	9.74	8.81	1.11	8.21	6.41	1.28
2013-2014	7.68	6.63	1.16	9.89	9.00	1.10	7.27	6.22	1.17

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.
 Source: National Survey on Drug Use and Health (NSDUH)

Figure 2.3.2. RI vs. US Adult Past Year Mental Health, 2009-2014



Source: National Survey on Drug Use and Health (NSDUH)

RI fares worse than most states in the region across all adult mental health indicators including past year serious mental illness, past year any mental illness, and having had at least one major depressive episode in the past year. RI has consistently fared worse than the national average across adult mental health indicators. In 2013-14, RI had the highest prevalence in the northeast region for any mental illness in the past year (Table 2.3.3).

Table 2.3.3. RI vs Region Adult (18+) Mental Health, 2009-2014

	CT	MA	ME	NH	NJ	NY	PA	VT	RI
	2009-10								
Past Year Serious Mental Illness (%)	3.73	4.20	4.14	4.25	3.39	3.72	3.57	4.04	4.92
Past Year Any Mental Illness (%)	17.63	18.51	18.70	19.76	17.54	19.02	17.53	19.75	21.30
At Least 1 Major Depressive Episode Past Year (%)	6.25	7.23	6.85	7.23	6.10	6.75	6.62	6.98	7.95
	2011-12								
Past Year Serious Mental Illness (%)	3.24	3.71	4.38	4.05	3.05	3.60	4.06	4.74	4.25
Past Year Any Mental Illness (%)	16.71	17.38	20.05	18.53	14.66	18.61	17.99	19.39	18.80
At Least 1 Major Depressive Episode Past Year (%)	6.20	6.19	7.33	7.17	5.43	6.24	6.89	7.79	7.65
	2012-13								
Past Year Serious Mental Illness (%)	3.38	4.25	4.94	3.94	3.28	3.75	4.05	5.48	4.90
Past Year Any Mental Illness (%)	17.26	19.34	21.36	18.64	15.62	18.69	17.96	19.74	20.13
At Least 1 Major Depressive Episode Past Year (%)	6.28	6.66	8.02	6.90	6.12	6.36	6.56	7.61	8.46
	2013-14								
Past Year Serious Mental Illness (%)	3.53	4.23	5.33	4.73	3.56	3.76	4.00	5.50	4.77
Past Year Any Mental Illness (%)	16.44	20.11	20.55	20.86	16.27	17.63	17.52	20.46	21.60
At Least 1 Major Depressive Episode Past Year (%)	6.03	7.50	8.21	7.90	6.47	6.32	6.61	7.94	7.68

Source: National Survey on Drug Use and Health (NSDUH)

Rhode Island mental health treatment admissions have increased substantially from 23,695 in 2012 to 27,015 in 2014. The gender and race/ethnicity distribution of these admissions has remained generally constant. However, treatment admissions for those under 18 years have increased, while admissions for those 65+ years have decreased. Diagnoses of bipolar disorder, schizophrenia, and major depression have steadily decreased from 2012-2014, while unknown diagnoses and other diagnoses have increased.

Table 2.3.4. Rhode Island Mental Health Admissions, 2012-2014

	2012	2013	2014
Total (N)	23,695	25,945	27,015
Gender			
Male	11622 (49.1%)	12825 (49.4%)	13494(50%)
Female	12069 (50.9%)	13116 (50.6%)	13517 (50%)
Age Group			
Under 18	3416 (14.4%)	4506 (17.4%)	5433 (20.1%)
18-21	2204 (9.3%)	2369 (9.1%)	2049 (7.6%)
22-30	2784 (11.8%)	3028 (11.7%)	3148 (11.7%)
31-45	5135 (21.7%)	5566 (21.5%)	5827 (21.6%)
45-65	8469 (35.7%)	8874 (34.2%)	9045 (33.5%)
Over 65	1687 (7.1%)	1602 (6.2%)	1513 (5.6%)
Race/Ethnicity			
Native American	343 (1.5%)	367 (1.4%)	349 (1.3%)
Asian	286 (1.2%)	297 (1.1%)	312 (1.2%)
Black	2315 (9.8%)	2556 (9.9%)	2834 (10.5%)
Hawaiian/Pacific Islander	36 (0.2%)	50 (0.2%)	50 (0.2%)
Hispanic	2258 (9.5%)	2316 (8.9%)	2434 (9%)
Unknown	1869 (7.9%)	2254 (8.7%)	2309 (8.6%)
White	16588 (70%)	18105 (69.8%)	18718 (69.3%)
Primary Diagnosis			
Adjustment Disorder	1567 (6.8%)	1633 (6.5%)	1707 (6.5%)
Anxiety	2476 (10.7%)	3007 (11.9%)	2975 (11.4%)
Attention Deficit Disorder	1427 (6.2%)	1541 (6.1%)	1439 (5.5%)
Bipolar Disorder	2073 (9%)	1903 (7.5%)	1717 (6.6%)
Major Depression	4002 (17.4%)	3970 (15.7%)	3623 (13.9%)
Other Mood Disorder	3782 (16.4%)	4161 (16.5%)	4040 (15.5%)
Schizophrenia	2201 (9.6%)	2002 (7.9%)	1796 (6.9%)
Unknown	3206 (13.9%)	4182 (16.6%)	5561 (21.3%)
Other*	2320 (9.8%)	2825 (11.2%)	3288 (12.6%)

*Other includes conduct disorder, personality disorder, dementia, autism, no diagnosis, and other psychotic or childhood disorders.

NOTE: These data reflect number of treatment admissions, not number of people.

Source: Rhode Island Behavioral Health On-Line Data Service (BHOLD)

SUMMARY

In terms of adult mental health, RI adults across all age groups had higher prevalence of serious mental illness in the past year, any mental illness in the past year, and having had at least one major depressive episode in the past year relative to national averages. Children in RI as compared to national averages who need mental health care do receive services and treatment; however, improvements in all mental

health issues can be developed. Additionally, major improvements are needed in RI around developmental screenings among children with special health care needs aged 10 months to 5 years who had health care and those who do not. Furthermore, improvements around early access of health care access and quality are needed.

2.4 CONSEQUENCES

In this Profile, we report on both potential short-term consequences:

- Overdose Deaths
- Intentional Self-Harm
- Suicide
- Assault (homicide)
- Fatal MV Crashes inv. Alcohol
- Drivers in Fatal MV Crashes inv. Alcohol
- Violent Crime
- Property Crime

and long-term consequences of substance use:

- Malignant Neoplasms Deaths
- Diseases of Heart Deaths
- Chronic Lower Respiratory Diseases Deaths
- Chronic Liver Disease and Cirrhosis Deaths
- DSM-IV Alcohol Abuse/Dependence
- DSM-IV Drug Abuse/Dependence

Consistent with federal guidance, we describe these as substance use “consequences” although we note that in some instances the relationship to Substance Use, Alcohol, and Mental Health may not be causal.

RI as compared to the US had larger prevalence rates for all long-term consequences resulting in death (Table 2.4.0). For short-term consequences, RI fares better than the national averages with the exception to fatal motor vehicle crashes involving alcohol. Additionally, when dealing with alcohol or drug abuse/dependence, Rhode Islanders had higher rates than the national average.

Table 2.4.0. RI vs US Potential Adverse Consequences of Substance Use, 2004-2012

Substance Use Consequences Indicators:	2004			2007			2010			2012		
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US
Malignant Neoplasms Deaths	2.24	1.89	1.19	2.09	1.87	1.12	2.15	1.86	1.16	2.045	1.856	1.10
Diseases of Heart Deaths	2.75	2.22	1.24	2.60	2.04	1.27	2.21	1.94	1.14	2.25	1.91	1.18
Chronic Lower Respiratory Diseases Deaths	0.43	0.42	1.03	0.40	0.42	0.94	0.48	0.45	1.08	0.48	0.46	1.05
Chronic Liver Disease and Cirrhosis Deaths	0.12	0.09	1.29	0.11	0.10	1.15	0.12	0.10	1.14	0.13	0.11	1.19
Intentional Self-harm (Suicide)	0.08	0.11	0.72	0.09	0.12	0.79	0.12	0.12	0.99	0.10	0.129	0.78
Assault (Homicide)	0.03	0.06	0.46	0.02	0.06	0.38	0.03	0.05	0.49	0.029	0.053	0.55
Fatal MV Crashes inv. Alcohol	45%	30%	1.50	31%	31%	1.00	40%	31%	1.29	39%	30%	1.30
Drivers in Fatal MV Crashes inv. Alcohol*	33%	24%	1.38	33%	26%	1.27	36%	26%	1.38	34%	25%	1.36
Violent Crime	2.47	4.63	0.53	2.27	4.72	0.48	2.57	4.05	0.63	2.52	3.87	0.65
Property Crime	28.84	35.14	0.82	26.23	32.76	0.80	25.57	29.46	0.87	25.72	28.59	0.90
DSM-IV Alcohol Abuse/Dependence	8.3%	7.8%	1.06	7.8%	7.5%	1.04	9.1%	6.8%	1.34	8.5%	6.7%	1.27
DSM-IV Drug Abuse/Dependence	3.6%	3.0%	1.19	4.4%	2.8%	1.57	2.9%	2.7%	1.07	3.7%	2.7%	1.37

Note: Ratios greater than 1.14 indicate those consequences where RI exceeds the national average. Ratios less than 0.86 indicate those consequences where RI is below the national average.

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

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

** Violent and Property Crimes U.S. Data taken from 2012 Table 1 Data

Sources: Fatality Analysis Reporting System (FARS), National Vital Statistics System (NVSS), Uniform Crime Reports (UCR)

Compared to other states in the Northeast, RI had higher rates for chronic liver disease and cirrhosis and diseases of the heart. Additionally, for DSM-IV alcohol and drug abuse/dependence, RI levels were higher than other states in the region. And finally, RI had higher rates of fatal motor vehicle crashes involving alcohol as well (Table 2.4.1).

Table 2.4.1. RI vs Region Potential Adverse Consequences of Substance Use, 2004-2012

	CT	MA	ME	NH	NJ	NY	PA	VT	RI
	2004								
Chronic Liver Disease and Cirrhosis	0.08	0.08	0.09	0.08	0.08	0.07	0.09	0.08	0.12
Diseases of Heart	2.25	2.15	2.24	2.03	2.36	2.73	2.94	2.07	2.75
Fatal MV Crashes inv. Alcohol	38%	35%	31%	31%	25%	28%	35%	22%	45%
DSM-IV Alcohol Abuse/Dependence	8.5%	8.0%	7.3%	7.8%	6.5%	6.9%	7.6%	8.7%	8.3%
DSM-IV Drug Abuse/Dependence	3.4%	3.2%	3.3%	2.9%	2.6%	3.0%	2.7%	3.1%	3.6%
	2007								
Chronic Liver Disease and Cirrhosis	0.08	0.09	0.12	0.09	0.07	0.07	0.09	0.09	0.11
Diseases of Heart	2.08	1.97	2.17	1.91	2.17	2.57	2.64	1.88	2.60
Fatal MV Crashes inv. Alcohol	37%	35%	35%	25%	27%	28%	33%	34%	31%
DSM-IV Alcohol Abuse/Dependence	8.2%	8.2%	6.9%	7.8%	6.8%	7.1%	7.0%	7.5%	7.8%
DSM-IV Drug Abuse/Dependence	2.9%	3.1%	2.9%	3.0%	2.4%	3.1%	2.4%	2.8%	4.4%
	2010								
Chronic Liver Disease and Cirrhosis	0.09	0.12	0.09	0.08	0.08	0.07	0.09	0.09	0.12
Diseases of Heart	1.99	1.84	1.98	1.74	2.13	2.32	2.48	1.87	2.21
Fatal MV Crashes inv. Alcohol	37%	34%	24%	31%	28%	30%	31%	23%	40%
DSM-IV Alcohol Abuse/Dependence	7.3%	8.4%	5.4%	6.7%	6.5%	6.7%	7.1%	7.2%	9.1%
DSM-IV Drug Abuse/Dependence	2.7%	2.8%	2.2%	2.9%	2.6%	2.7%	2.7%	3.4%	2.9%
	2012								
Chronic Liver Disease and Cirrhosis	0.09	0.09	0.11	0.09	0.08	0.08	0.10	0.07	0.13
Diseases of Heart	2.03	1.75	1.97	1.76	2.07	2.24	2.43	1.93	2.25
Fatal MV Crashes inv. Alcohol	35%	34%	28%	29%	27%	29%	31%	32%	39%
DSM-IV Alcohol Abuse/Dependence*	7.1%	7.1%	6.4%	7.6%	6.6%	6.6%	6.5%	6.8%	8.5%
DSM-IV Drug Abuse/Dependence*	2.5%	2.8%	2.6%	2.9%	2.2%	2.7%	2.8%	2.9%	3.7%

DSM-IV Alcohol & Drug Abuse or Dependence Percentages for 12+ Age Group

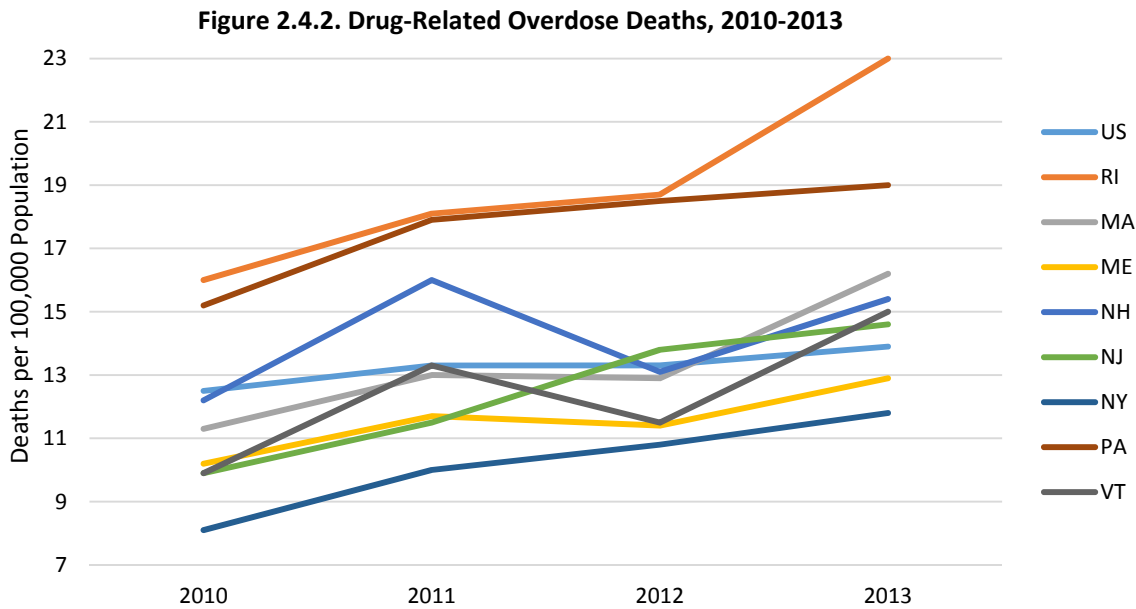
Source: National Vital Statistics System (NVSS)

Since 2010, RI has consistently surpassed the national average for drug-related overdose deaths. RI also has consistently fared worse than all other northeastern states in terms of drug-related overdose deaths (Table 2.4.2). However, data were unavailable for Connecticut. A key limitation of these data is that drug-related overdose deaths could be due to prescription drugs (e.g. opioids, benzodiazepines, stimulants) or street drugs (e.g. alcohol, cocaine, amphetamines, and heroin). Given the broad scope encompassed by “drug-related overdose deaths,” it is challenging to infer intervention implications.

Table 2.4.2. RI vs. Region Drug-Related Overdose Deaths per 100,000 Population

	USA	RI	CT	MA	ME	NH	NJ	NY	PA	VT
2010	12.5	16.0	--	11.3	10.2	12.2	9.9	8.1	15.2	9.9
2011	13.3	18.1	--	13.0	11.7	16.0	11.5	10.0	17.9	13.3
2012	13.3	18.7	--	12.9	11.4	13.1	13.8	10.8	18.5	11.5
2013	13.9	23.0	--	16.2	12.9	15.4	14.6	11.8	19.0	15.0

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.
 Source: Death certificate data: National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Mortality Detail files, 2010-2013.



Source: Death certificate data: National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Mortality Detail files, 2010-2013.

Emergency department visits in RI for prescription drug overdose have increased from 2010 to 2014, though the number of visits peaked in 2012. Approximately one quarter of emergency department visits were for residents under the age of 21 years, though this proportion appears to be slowly decreasing. Hospital admissions related to prescription drug overdose in RI have actually decreased from 2010 to 2014, though there was an increase from 2013 to 2014. About 17% of hospital admissions were for residents under the age of 21 years—and this proportion has remained steady (Table 2.4.3). A key limitation of these data is that prescription drug overdose visits or admissions could be due to prescription drug use (e.g. opioids, benzodiazepines, stimulants) or street drug use (e.g. fentanyl, heroin). Again this limitation is a barrier for inferring intervention implications.

Table 2.4.3. Prescription Drug Overdose in Rhode Island, 2010-2014

ED Visits Related to Prescription Drug Overdose					
	2010	2011	2012	2013	2014
Total	362,440	367,635	380,323	371,010	375,342
Under 21 (%)	26	25	24	23	23
21+ (%)	74	75	76	77	77
Hospital Admissions Related to Prescription Drug Overdose					
	2010	2011	2012	2013	2014
Total	132,147	130,832	126,358	120,786	124,243
Under 21 (%)	17	17	17	17	16
21+ (%)	83	83	83	83	84

Source: Hospital Database, Rhode Island Department of Health

RI high school students are less likely to consider suicide or plan suicide than the national average. However, RI high school students were more likely to attempt suicide than the national average in 2013 (Table 2.4.4). Yet, the 2015 prevalence for suicide attempts among high school students has decreased since 2013. RI adults were more likely to have thoughts of suicide in the past year than the national average, particularly for adults aged 26 years or more (Table 2.4.5).

Table 2.4.4. RI vs. US Suicide-Related Indicators, 2009-2015

% of Students (grades 9-12) Reporting:	2009			2011			2013			2015
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI
Considered Suicide	11.8	13.8	0.86	12.3	15.8	0.78	13.9	17.0	0.82	14.1
Planned Suicide	11.3	10.9	1.04	10.7	12.8	0.84	9.9	13.6	0.73	12.1
Attempted Suicide	7.7	6.3	1.22	8.7	7.8	1.12	14.3	8.0	1.79	10.6

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: Youth Risk Behavior Surveillance Survey (YRBSS)

Table 2.4.5. RI vs. US Thoughts of Suicide Past Year, 2009-2014

% of Age Group Reporting:	18+			18-25			26+		
	RI	US	Ratio RI/US	RI	US	Ratio RI/US	RI	US	Ratio RI/US
2009-2010	4.56	3.78	1.21	6.90	6.36	1.08	4.11	3.33	1.23
2011-2012	4.05	3.77	1.07	6.89	7.03	0.98	3.51	3.21	1.09
2012-2013	4.33	3.89	1.11	7.34	7.33	1.00	3.75	3.30	1.14
2013-2014	4.21	3.94	1.07	7.92	7.44	1.06	3.50	3.34	1.05

Note: Ratios greater than 1.14 indicate those consumption patterns where RI exceeds the US average. Ratios smaller than 0.86 indicate those consumption patterns where RI is lower than the US average.

Source: National Survey on Drug Use and Health (NSDUH)

There is a need for work to be done to make a difference for both short- and long-term consequences. Again, the data presented here regarding substance or alcohol and health consequences are not causal. There are many reasons and factors contributing to these various short- and long-term consequences ultimately leading to death.

SUMMARY

The short- and long-term consequences reported in this Profile should be taken as is without causal inferences in relation to substance and alcohol use. RI as compared to national estimates had higher rates of malignant neoplasm deaths, heart disease deaths, chronic lower respiratory infection deaths, chronic liver disease and cirrhosis deaths, fatal motor vehicle crashes involving alcohol, drivers in fatal motor vehicle crashes involving alcohol, DSM-IV alcohol abuse/dependence and DSM-IV drug abuse/dependence. Further, in 2012, RI also fared worse than all other states in the region for chronic liver disease and cirrhosis deaths, fatal motor vehicle crashes involving alcohol, DSM-IV alcohol abuse/dependence and DSM-IV drug abuse/dependence. Thoughts of suicide among adults 18+ in RI has consistently been more prevalent than the national average over time. Among high school students in RI, the rate of suicide attempts has also been consistently above the national average. Finally, RI drug related overdose deaths has been consistently higher than all other states in the region as well as the national average since 2010; this rate also appears to be on the rise. Further work needs to be done to determine a better picture of the relationship between substance and alcohol consumption and patterns with health outcomes.

2.5. RISK AND PROTECTIVE FACTORS

Substance and alcohol consumption and patterns are influenced by multiple factors affecting exposure and risk. The environment for one, could impact exposure to and risk for substance and alcohol consumption. Table 2.5.0 shows RI versus regional comparison of student reports of illegal drugs on school property from 2001 to 2013. RI as compared to the US had greater averages with the exception in 2011. 22.6% of students in RI reported ever been exposed to illegal drugs on school property. When compared to other regional states, RI had lower averages than CT, MA, and NJ but higher than MA and ME. More work could be done to reduce the exposure of children in a school setting to illegal drugs and other substances.

Table 2.5.0. RI vs. Region Illegal Drugs on School Property, 2001-2013

USA	RI	CT	MA	ME	NH	NJ	NY	PA	VT
Ever illegal drugs on school property									
2001	28.5	30.9	--	34.2	32.4	--	28.8	--	29.6
2009	22.7	25.2	28.9	26.1	21.2	22.1	32.2	24.0	16.1
2011	25.6	22.4	27.8	27.1	21.7	23.1	27.3	--	17.6
2013	22.1	22.6	27.1	23.0	18.4	20.1	30.7	--	--

Note: RI Indicators greater than national averages are shown in red.

RI indicators less than national averages are shown in green.

Source: Youth Risk Behavior Surveillance System (YRBSS)

3. DATA LIMITATIONS AND GAPS

Even though this Profile seeks to provide a comprehensive summary of substance use and mental health-related indicators and risk or protective factors in the state of RI, there are data-related limitations that the reader should keep in mind.

- The Profile is limited by the availability, accuracy and comprehensiveness of the original sources of data. Therefore, most recent years of data or demographic break-downs of indicators may not always be available. Every effort will be made to keep the Profile up-to-date.
- It is recommended that the reader review the Data Sources described in the Appendices to better understand the advantages and limitations inherent in each of the original data sources used for this Profile.
- Data provided in this Profile are presented in crude form, without any demographic adjustments. Also, confidence intervals for these estimates were not included.
- While described as substance use “consequences”, the short- and long-term consequences described in Section 2.4 may not reflect a direct causal result of alcohol and substance use. At this time, the Profile focuses primarily on the underage population as the key demographic sub-group of interest. Additionally, demographic breakdown to include racial and the start of health-status breakdowns were added to this version. Future Profiles will aim to continue and extend demographic breakdowns to additional populations of interest, and include more racial, gender, and health-status breakdowns.
- Rhode Island is densely populated, highly urban, and the smallest state in the US. It is also in close proximity to other large cities in the New England corridor (e.g. Boston, New York City).

4. SUMMARY

The Profile contains most relevant data on statewide substance use and abuse (consumption patterns), alcohol consumption patterns, mental health, short- and long-term consequences, and risk and protective factors. Additionally, substance use and abuse, alcohol consumption patterns, and short- and long-term consequences for RI are compared to national and regional results, including other states in New England and the Tri-State region. New to this Profile are more in-depth data on the RI demographic context. This Profile included more data of population, age groups, specific racial and ethnic groups, foreign born and language, education, income, labor force data including unemployment rates, homelessness status, and

health insurance coverage. In addition, this Profile provided data by age group and time-trends for many of the topics presented. Keeping the inherent limitations in mind, the data summarized in the Profile can therefore be utilized for promotion, prevention, treatment, recover and health-care planning for the State of Rhode Island.

5. APPENDICES

5.1 DATA SOURCES

A complete list of data sources utilized in this report is presented in Table 5.1.0.

Source	Sponsoring Agency	Methodology
<p>Annual Homeless Assessment Report (AHAR)</p> <p>The Annual Homeless Assessment Report reports provide the latest counts of homelessness nationwide – including counts of individuals, persons in families, and special population groups such as veterans and chronically homeless people.</p> <p>https://www.hudexchange.info/hdx/guides/ahar/</p>	<p>United States Department of Housing and Urban Development (DHUD)</p>	<p>The AHAR is based on two data sources, 1) one-night, Point-in-Time (PIT) counts of both sheltered and unsheltered homeless populations and 2) Homeless Management Information System (HMIS) electronic administrative databases designed to record and store client-level information on homeless persons.</p> <p>Frequency of Assessment: Annual.</p> <p>Target Population: United States</p>
<p>Behavioral Risk Factor Surveillance System (BRFSS)</p> <p>A state-based system of health surveys that collects information on health risk behaviors, preventative health practices, and health care access primarily related to chronic disease and injury.</p> <p>http://www.cdc.gov/brfss/index.htm</p>	<p>The Centers for Disease Control and Prevention (CDC)</p>	<p>A cross-sectional telephone survey conducted by state health departments with technical and methodological assistance provided by the CDC.</p> <p>Frequency of Assessment: Data collected monthly every year.</p> <p>Target Population: Non-institutionalized adults in the United States.</p>

<p>Bureau of Labor Statistics (BLS)</p> <p>The BLS is the principal fact-finding agency for the Federal Government in the broad field of labor economics and statistics. The mission of BLS is to collect, analyze, and disseminate essential economic information to support public and private decision-making.</p> <p>http://www.bls.gov</p>	<p>United States Department of Labor</p>	<p>The Local Area Unemployment Statistics (LAUS) program produces labor force data. The Current Population Survey (CPS) is a monthly survey of households conducted by the Bureau of Census for the BLS, providing data on the labor force, employment, unemployment, persons not in the labor force, hours of work, earnings, and other demographic and labor force characteristics.</p> <p>Frequency of Assessment: Monthly and Annual.</p> <p>Target Population: United States</p>
<p>Fatality Analysis Reporting System (FARS)</p> <p>A nationwide census providing NHTSA, Congress, and the American public yearly data regarding fatal injuries suffered in motor vehicle traffic crashes.</p> <p>http://www.nhtsa.gov/FARS</p>	<p>The National Highway Traffic Safety Administration (NHTSA)</p>	<p>The FARS is a crash census system in which a set of files has been built documenting all qualifying fatal crashes. To be included, a crash had to involve a motor vehicle traveling on a traffic way customarily open to the public, and must have resulted in the death of a motorist or a non-motorist within 30 days of the crash.</p> <p>Frequency of Assessment: Annual.</p> <p>Target Population: United States</p>
<p>Pregnancy Risk Assessment Monitoring System (PRAMS)</p> <p>A surveillance project that collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy.</p> <p>http://www.cdc.gov/prams</p>	<p>The Centers for Disease Control and Prevention (CDC)</p>	<p>The sample of women who have had a recent live birth is drawn from the state's birth certificate file. Women from some groups are sampled at a higher rate to ensure adequate data are available in smaller but higher risk populations. Data collection procedures and instruments are standardized to allow comparisons between states.</p> <p>Frequency of Assessment: Annual.</p> <p>Target Population: Women in the United States who have a recent live birth.</p>

<p>National Survey of Children’s Health (NSCH)</p> <p>A national telephone survey that provides a broad range of data and information about children’s health and well-being.</p> <p>http://www.nschdata.org</p>	<p>The Maternal and Child Health Bureau</p>	<p>Telephone-based survey of households in the United States completed by parents for children between the ages of 0-17 years. Survey results are weighted to represent the population of non-institutionalized children ages 0-17 nationally and in each state.</p> <p>Frequency of Assessment: Conducted in 2003, 2007, 2011-12</p> <p>Target Population: United States</p>
<p>National Survey of Drug Use and Health (NSDUH)</p> <p>A survey that provides national and state-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States.</p> <p>http://nsduhweb.rti.org</p>	<p>The Substance Abuse and Mental Health Services Administration (SAMHSA)</p>	<p>A scientific random sample of US households, with the professional interviewer visiting each selected household. After answering a few general questions, one or two residents of the household may be asked to participate in the survey by completing an interview.</p> <p>Frequency of Assessment: Annual.</p> <p>Target Population: Individuals in the United States aged 12 and older.</p>
<p>National Vital Statistics System (NVSS)</p> <p>The National Center for Health Statistics (NCHS) collects and disseminates the Nation’s official vital statistics. These data are provided through contracts between NCHS and vital registration systems legally responsible for the registration of vital events – births, deaths, marriages, divorces, and fetal deaths.</p> <p>http://www.cdc.gov/nchs/nvss.htm</p>	<p>The Centers for Disease Control and Prevention (CDC)</p>	<p>Data are provided through contracts between NCHS and vital registration systems legally responsible for the registration of vital events. Standard forms for the collection of the data and model procedures for the uniform registration of the events are developed and recommended for nationwide use.</p> <p>Frequency of Assessment: On-going; published annually.</p> <p>Target Population: All deaths occurring in the United States.</p>
<p>The Rhode Island Department of Children, Youth and Families (RI DCYF)</p> <p>The mission of DCYF is to assist families with their primary responsibility to raise their children to become productive members of society. The Data and Evaluation Office performs and coordinates data analysis on families and children in DCYF care to guide program development, evaluate programs and inform policies.</p> <p>http://www.dcyf.ri.gov/data_evaluation.php</p>	<p>The Rhode Island Secretariat for Health and Human Services (EOHHS)</p>	<p>The Rhode Island Family Information System (RIFIS) is the data collection system for the Family and Community System of Care (FCSC) initiative of the RI DCYF. The lead and partner agencies within the Family Care Community Partnerships (FCCPs) use RIFIS to track the child, family and service information associated with wraparound service planning and delivery.</p> <p>Frequency of Assessment: On-going; Annually</p> <p>Target Population: Children, Youth, and Families of Rhode Island</p>

<p>Rhode Island Kids Count</p> <p>RI Kids Count is a statewide children’s policy organization that provides independent, credible, comprehensive information on Rhode Island’s children.</p> <p>http://www.rikidscount.org</p>	<p>Annie E. Casey Foundation</p>	<p>Data acquired from various state and community level sources.</p> <p>Frequency of Assessment: Varies</p> <p>Target Population Children and youth of Rhode Island</p>
<p>School Health Profiles</p> <p>Developed by the Centers for Disease Control and Prevention (CDC), in collaboration with state and local education and health agencies, to measure school health policies and practices.</p> <p>http://www.cdc.gov/healthyyouth/profiles</p>	<p>The Centers for Disease Control and Prevention (CDC)</p>	<p>A system of surveys assessing school health policies and practices in states, large urban school districts, territories, and tribal governments. School Health Profiles are conducted by education and health agencies among middle and high school principals and lead health education teachers.</p> <p>Frequency of Assessment: Every two years.</p> <p>Target Population: Youth in the United States who attend elementary and secondary schools.</p>
<p>Uniform Crime Reports (UCR)</p> <p>The UCR Program is a voluntary city, university and college, county, state, tribal and federal law enforcement program that provides a nationwide view of crime based on the submission of statistics by law enforcement agencies throughout the country.</p> <p>http://www.fbi.gov/about-us/cjis/ucr</p>	<p>Federal Bureau of Investigation (FBI)</p>	<p>Data collected from State agencies. Within the UCR Program, there are two methods of collecting crime data: the traditional Summary reporting system and the National Incident-Based Reporting System (NIBRS). To ensure these data are uniformly reported, the FBI provides contributing law enforcement agencies with a handbook that explains how to classify, define, and score offenses.</p> <p>Frequency of Assessment: Annual.</p> <p>Target Population: United States</p>
<p>United States Census</p> <p>The United States Census counts every resident in the United States.</p> <p>http://www.census.gov/programs-surveys/decennial-census.html</p>	<p>United States Census Bureau</p>	<p>The United States Census tells us who we are and where we are going as a nation. States use the census to redraw their congressional districts. Communities use it to plan where to build schools, roads, and hospitals. Governments use it to allot funds and support.</p> <p>Frequency of Assessments: Every 10 years.</p> <p>Target Population: Every resident in the United States.</p>

<p>Youth Risk Behavior Surveillance System (YRBSS)</p> <p>Monitors priority health-risk behaviors and the prevalence of obesity and asthma among youth and young adults.</p> <p>http://www.cdc.gov/HealthyYouth/yrbs</p>	<p>The Centers for Disease Control and Prevention (CDC)</p>	<p>YRBSS includes a national school-based survey conducted by CDC as well as state, territorial, and local school-based surveys conducted by education and health agencies.</p> <p>Frequency of Assessments: Bi-Annual.</p> <p>Target Population: Students in grades 9-12 in the United States.</p>
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5.2 SEOW MEMBERSHIP

Organizational Affiliation	SEOW Role/Responsibility	Member Name
Drug and Alcohol Treatment Association (DATA) of RI	Member: attend meetings, respond to interim communications, and draft/review committee products	David Spencer
Governor's Council on Behavioral Health	Member: attend meetings, respond to interim communications, and draft/review committee products	Richard Leclerc
RI Council of Community Mental Health	Member: attend meetings, respond to interim communications, and draft/review committee products	Barbara Inderlin
University of RI	Member: attend meetings, respond to interim communications, and draft/review committee products	Dr. Paul Florin
Brown University	Staff Co-Chair	Dr. Stephen Buka
Brown University	Staff Research Associate	Dr. Samantha Rosenthal
RI Department of Children, Youth and Families	Staff Co-Chair	Dr. Colleen Caron
RI Department of Education	Member: attend meetings, respond to interim communications, and draft/review committee products	Dr. Midge Sabatini
RI Department of Health	Member: attend meetings, respond to interim communications, and draft/review committee products	Tara Cooper
RI Department of Health	Member: attend meetings, respond to interim communications, and draft/review committee products	Sam Viner-Brown
RI Department of Human Services	Member: attend meetings, respond to interim communications, and draft/review committee products	Ann Martino
RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals	Staff Project Director/Manager	Linda Barovier
RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals	Staff Project Supervisor	Elizabeth Kretchman