Governor Dan McKee's Overdose Task Force
July 8, 2026

Richard Leclerc; Director, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals
Jerome Larkin, MD; Director, Rhode Island Department of Health
Alex Gautieri, MSW, LCSW; Task Force Community Co-Chair
Ana Novais, MA; Assistant Secretary, Rhode Island Executive Office of Health and Human Services
Cathy Schultz, MPH; Task Force Director, Rhode Island Executive Office of Health and Human Services

RHODE ISLAND

Welcome and Announcements

RHODE ISLAND

Scan the QR Codes for a Free Medicine Lock Bag or Naloxone Kit

Save the Dates!

Changes in Monitoring Non-Fatal Overdoses in Rhode Island

July 8, 2026

Governor's Overdose Task Force

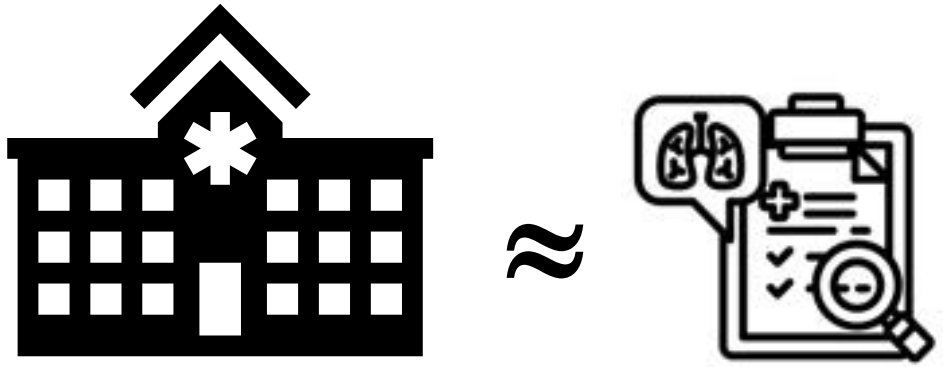
RHODE ISLAND DEPARTMENT OF HEALTH

How Does RIDOH Use Non-Fatal Overdose Data?

To identify communities at high risk for substance use-related harms.

Uses

- Create overdose heat maps for mobile outreach
- Identify communities for prevention efforts
- Inform tailored prevention activities
- Locate overdose spikes for immediate response



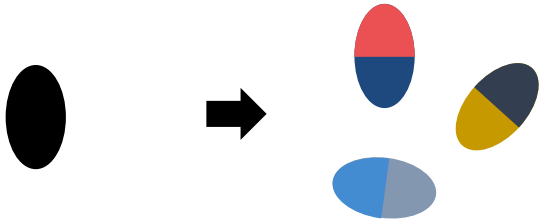
Transitioning to a New Non-Fatal Overdose Data Source

In 2026, RIDOH transitioned from the Integrated Surveillance System (ISS) to the **Overdose Spike Alert System (OSAS)** for monitoring non-fatal overdose trends.

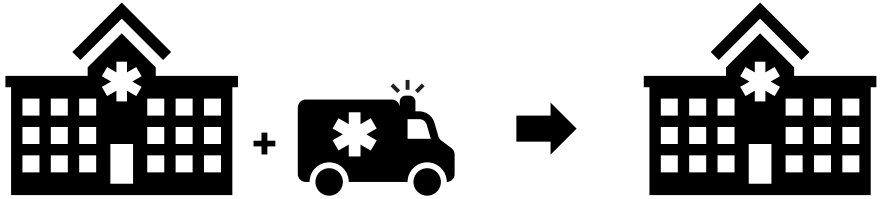
Non-Fatal Overdose Spike Alert System		Last 7-Day Period	Activity 06/24/26 - 06/30/26		Last 6-Month Period	Burden 01/02/26 - 06/30/26
Region #	Region		Threshold	Count		Regional Rate Compared to Statewide Rate
	Statewide		63	49		209 Per 100,000 Population
1	Burrillville, Foster, Glocester, Scituate		3	Less Than 5		↓ Less than the statewide rate
2	Woonsocket		7	Less Than 5		↑ 1.5 to 2 times greater than the statewide rate
3	Cumberland, Lincoln, Smithfield, North Smithfield		7	5		↓ Less than the statewide rate
4	Johnston, North Providence		5	0		↓ Less than the statewide rate
5	Central Falls, Pawtucket		9	5		— Similar to the statewide rate
6	Providence		21	13		↑ 1.5 to 2 times greater than the statewide rate
7	Cranston		6	Less Than 5		↓ Less than the statewide rate
8	Warwick, West Warwick, Coventry		13	9		— Similar to the statewide rate
9	Jamestown, Bristol, East Providence, Warren, Portsmouth, Tiverton, Little Compton, Middletown, Newport, Barrington		10	6		↓ Less than the statewide rate
10	East Greenwich, West Greenwich, Exeter, Richmond, Hopkinton		4	Less Than 5		↓ Less than the statewide rate
11	Charlestown, North Kingstown, South Kingstown, Narragansett, Westerly, Block Island		7	Less Than 5		↓ Less than the statewide rate

Non-Fatal Overdose Monitoring in Rhode Island

The new system provides more robust data and better monitors the ever-changing overdose epidemic.



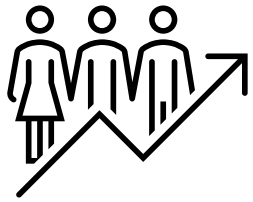
Monitoring more substances



Real-time data from EDs only

Non-Fatal Overdose Monitoring in Rhode Island

Residence location



More complete demographic data

Overdose associated with suicidal ideation

Why Include More Substances?

To better address the overdose epidemic in Rhode Island and ensure we are serving all populations.

- Identify and address racial disparities.
  - In 2025, 88% of fatal overdoses among Non-Hispanic Black individuals involved stimulants.
- Address the role of prescribed, over-the-counter, and illicit substances.
- As expected, overdose counts increased more than 2.5 times.

Example	December 2025	January 2026
Non-Fatal Overdose ED Visits	65	212

Residence Location

Residence location identifies where people are more likely to experience fatal overdoses.

- Most Rhode Island residents lose their lives to overdose (77%) in their homes.
- Extensive outreach and community response have decreased the likelihood of overdose in public settings.
- *Note*: *Overdose incident locations are also reviewed if a region meets or exceeds its overdose threshold.*

Continuing to Adjust the Response

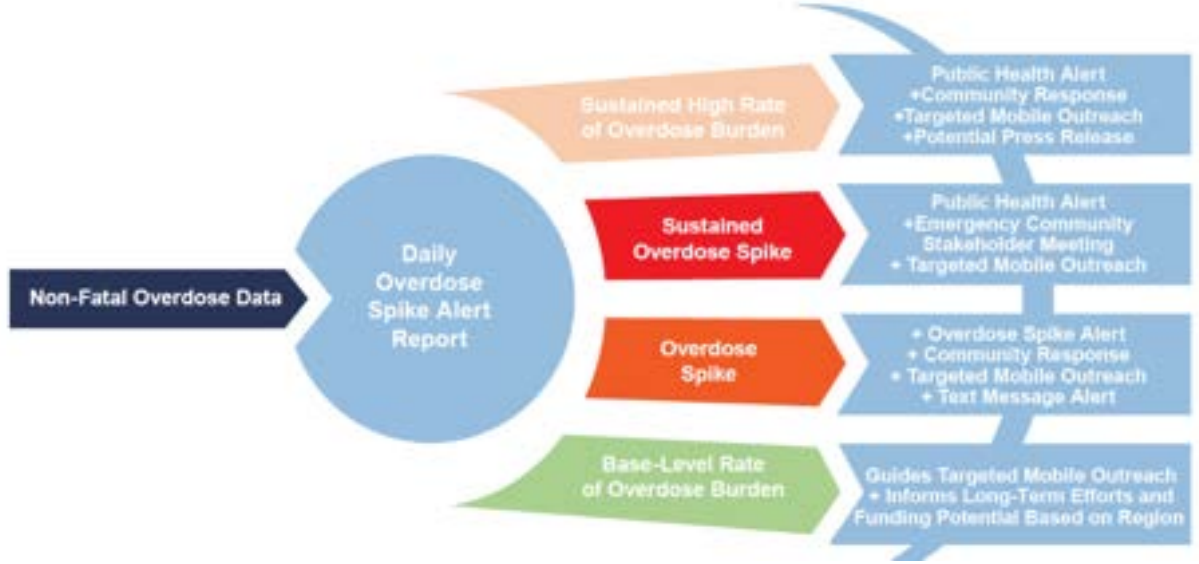
- **Center the response** on where people call "**home.**"
- **In addition to outreach teams, community leaders and residents are made aware of their municipality's** elevated overdose risk.
- Mobilize a **broad, community-wide response** involving primary care providers, educators, faith leaders, local government, businesses, treatment facilities, recovery community centers, harm reduction organizations, prevention coalitions, Health Equity Zones (HEZ), and other local partners.
- **"All-hands-on-deck" response** that is more **coordinated** and **sustainable.**

Next Steps

Adjusting overdose response via the Overdose Spike Alert System.

- Elicit community feedback for both the spike alert process and messaging.
- Update the Levels of Response.
- Open to suggestions! Please reach out with your thoughts and suggestions.

Levels of Response, 2025



Thank you!

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COMMUNITY DRUG CHECKING IN RHODE ISLAND

Traci Green, PhD, MSc | COBRE on Opioids and Overdose, Brown University Schools of Medicine and Public Health

Rachel Serafinski, MA | COBRE on Opioids and Overdose, Brown University Health

Merci Ujeneza, BS | COBRE on Opioids and Overdose, Brown University Health

WHAT IS COMMUNITY DRUG CHECKING?

Drug checking is one way to learn more about what is in the drug supply.

- FREE and ANONYMOUS service that quickly provides information about what substances are in a drug sample.
- Allows people to make informed decisions about whether and how much to use, to plan and be more prepared when using.
- Operational in multiple countries and states for decades.

COBRE DRUG CHECKING

Community Use and Testing Study (CUTS) Teams

Traci Green
Michelle McKenzie
Merci Ujeneza
Rachel Serafinski
Maurice Newman
Michaela Whitley
Juan Turbidez

Mary Figgatt
Greg Rosen
Ju Park
Jody Rich
Susan Ramsey
Jef Bratberg
Adina Badea

COMMUNITY PARTNERS

Project Weber/RENEW
AIDS Care Ocean State
Safe Haven
CODAC Behavioral Healthcare
VICTA
Brown University Health: Street Medicine, Recovery Center, and Addiction Care Today (ACT) Clinic

Funding

National Institute on General Medical Sciences
National Institute on Drug Abuse

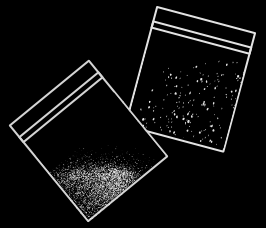
COMMUNITY DRUG CHECKING

Community drug checking in Rhode Island is currently available through the COBRE on Opioids and Overdose and CUTS.

While CUTS is entering its final follow-up period, the COBRE will continue community drug checking as we can.

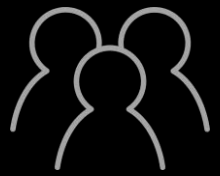
2022 - 2023

National Institutes of Health-funded efforts: Building drug checking services at the COBRE, pilot project, and CUTS cohort begin.



THROUGHOUT CUTS

Drug checking was available to CUTS-enrolled participants and the broader community through COBRE efforts.



NOW

As the CUTS research winds down, community drug checking continues through COBRE operations.

WHAT HAPPENS DURING DRUG CHECKING

EXAMPLE:
Substances Identified:
- **Mannitol (Major)**
- **Fentanyl (Minor)**
- **Xylazine (Trace)**
- **BTMPS (Trace)**

1

SOMEONE BRINGS IN A SAMPLE OR DROPS ONE OFF

2

WHAT WAS IT EXPECTED TO BE?

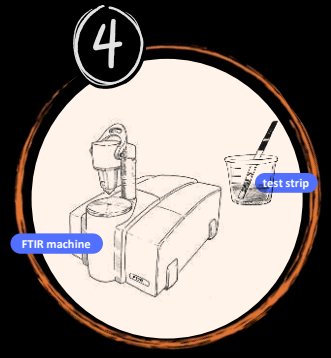
We talk through expectations

3

WHAT DID THEY NOTICE? HOW DID IT FEEL?

We talk through their experience

4



WE TEST THE SAMPLE

FTIR and Test Strips

5

WE MAKE SENSE OF THE RESULTS TOGETHER

What might explain their experience

6

WHAT HAPPENS NEXT?

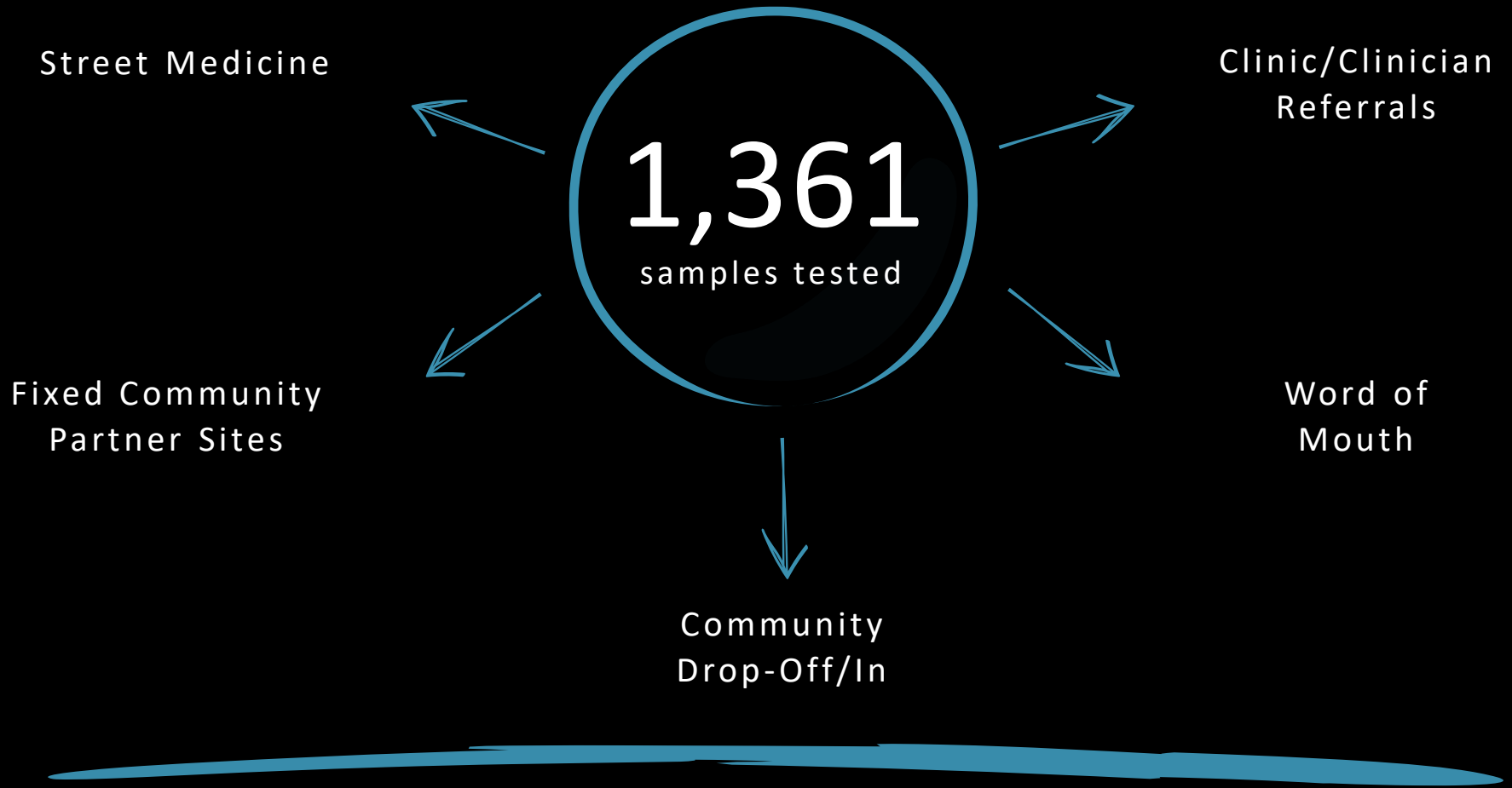
- Share information
- Discuss prevention and risk reduction strategies
- Decide next steps
- Come back to test again

Testing + conversation + results in ~ 20 minutes

Complementary laboratory results ~ 3 weeks

Drug checking does not tell someone whether a drug is safe. It gives them more information about the sample tested.

HOW PEOPLE FIND US



600 ENROLLED CUTS PARTICIPANTS

Median age: 43 | 64% men, 34% women, 2% non-binary/transgender

From diverse racial and ethnic backgrounds: half identified as people of color

PEOPLE NOTICE THE SUPPLY CHANGING FIRST

People often come to drug checking because they're curious or something has changed.

"If I bought from a new dealer, I would test it."

1. WHAT AM I USING?
2. IS THIS MY NORMAL DRUG?
3. DID SOMETHING CHANGE?
4. HOW DO I STAY SAFER?
5. HOW CAN I TEACH OTHERS?

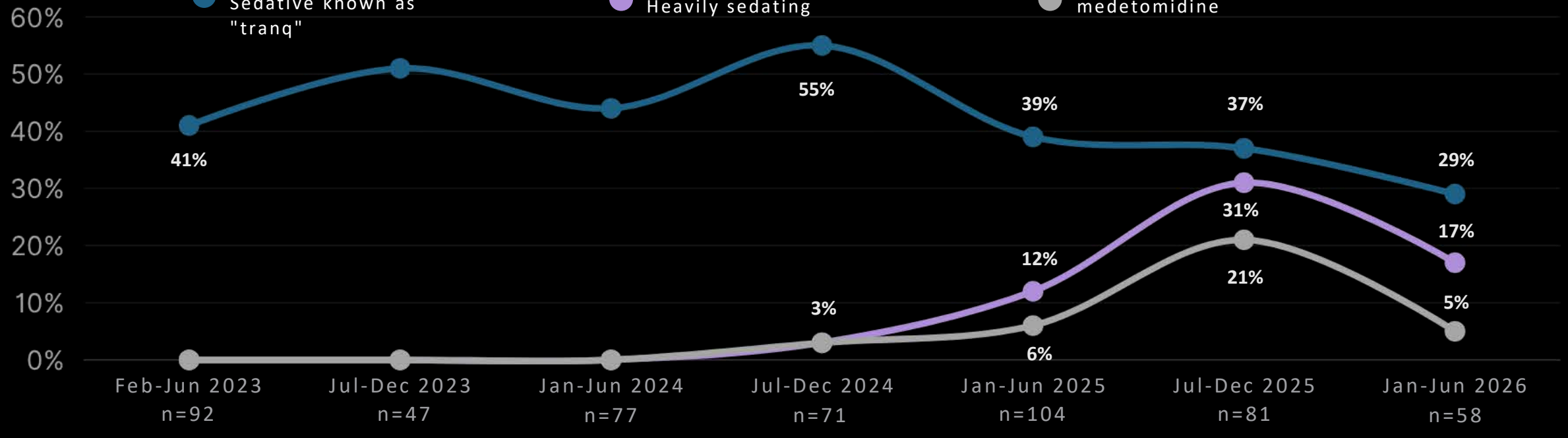
A CHANGING SUPPLY: OPIOIDS

As patterns shift, people describe changes in sedation, strength, duration, and how samples feel.

Xylazine was commonly detected **2023**

Medetomidine was first detected in opioid samples **2024**

Xylazine + medetomidine detected together often **2025–2026**



A CHANGING SUPPLY: COCAINE/CRACK

As additives and fillers shift, people describe changes in taste, strength, and how samples respond when smoked.

2023

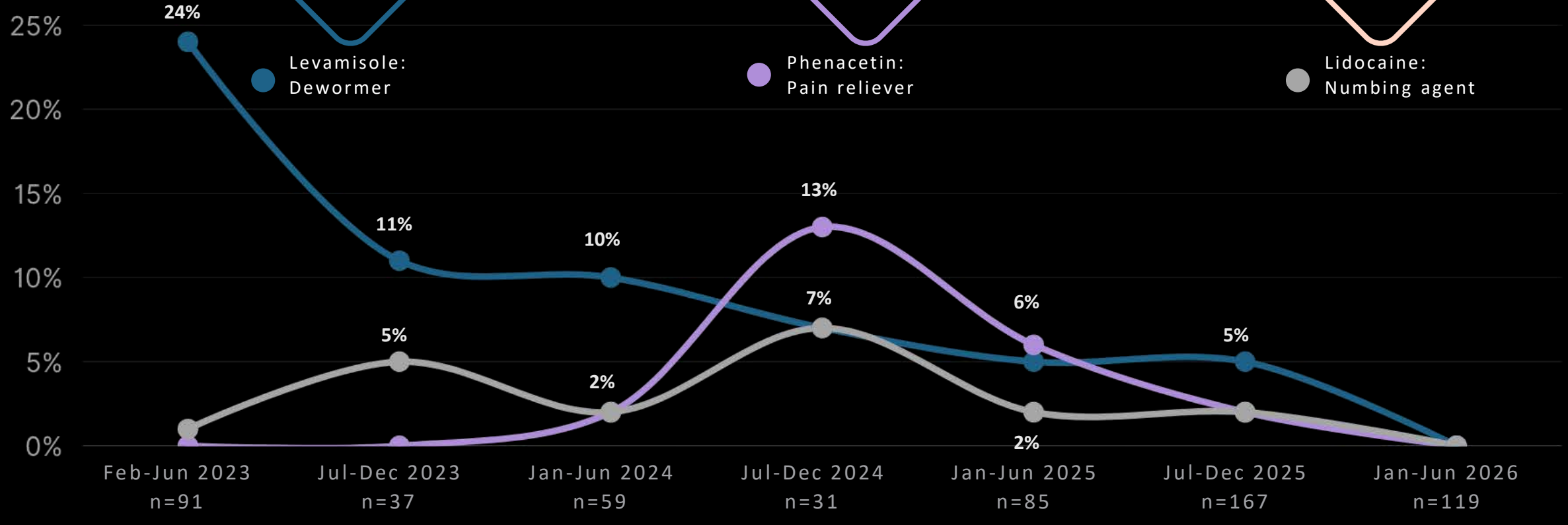
Levamisole was more commonly detected

2024-2025

We started seeing levamisole, phenacetin, and lidocaine

Recently

Fewer active additives detected, fillers/ inactives present



PEOPLE NOTICE CHANGES

These shifts are not just visible in the testing data. People notice changes in how they feel, how they taste, and what they see happen around them.

Fentanyl was weaker, but was very sedated from something else.

Don’t nod out, just go straight to sleep.

People are falling asleep for hours on this sample.

Detected:
Fentanyl
Xylazine

Dropped for 10 plus hours… pins and needles in face and head… almost similar to ketamine dissociation.

Heavy sedation, possible hallucinations.

Shorter duration than normal but very intense experience.

Detected:
Fentanyl
Medetomidine
Others

Taste like a pill/medicine out of the ordinary.

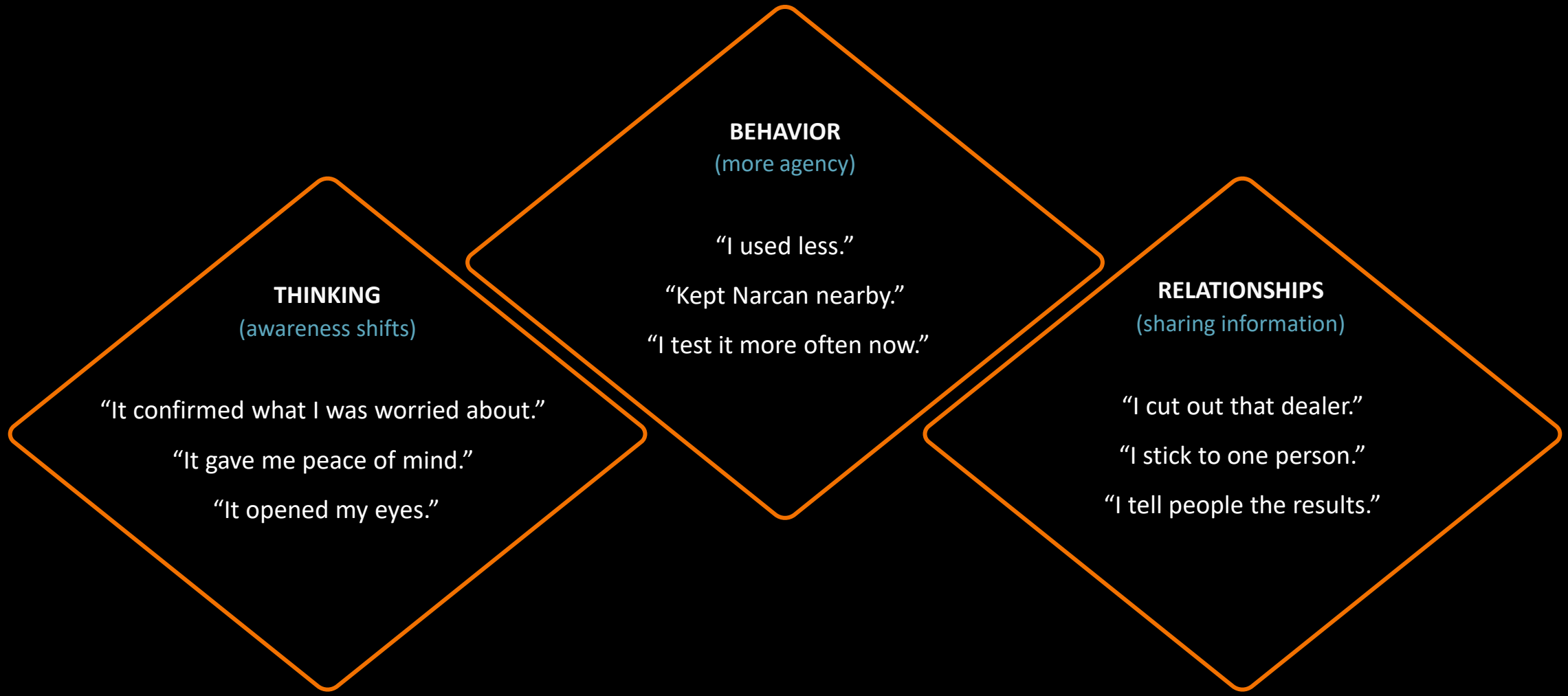
Same feeling but weird taste.

Bad taste… checking for fentanyl.

Detected:
Cocaine
Levamisole

WHAT CAN CHANGE AFTER DRUG CHECKING?

The result is not the endpoint; it becomes information people use.



DRUG CHECKING AS A BRIDGE TO CARE

An example of how that information can become a conversation about care, safety, and what to do next.

The individual

Came in after seeking care for suspected pink eye and were prescribed antibiotics, but they were not helping. So, they wanted to test their cocaine.

Drug checking

The sample showed **cocaine + levamisole (higher than typical levels)**. Levamisole = attacking the blood, skin, and nervous system and is known to cause a range of eye problems.

Care navigation

Because a nurse was on site, staff offered to write down the result and symptoms to bring with them. This created a way for their use experience and the sample result to be brought into a care conversation.

WHAT COULD DRUG CHECKING LOOK LIKE WITHIN RHODE ISLAND'S PUBLIC HEALTH RESPONSE?

BROADER COMMUNITY/ PUBLIC

ADD TO RHODE ISLAND'S PUBLIC HEALTH RESPONSE

EXAMPLE:

Substances Identified:

- **Mannitol (Major)**
- **Cellulose (Trace)**
- **Fentanyl (Trace)**
- **Cychlorphine (Trace)**

available on streetcheck.org

COMMUNITY PARTNER

SUPPORTS OUTREACH + OVERDOSE RESPONSE + COMMUNITY MESSAGING

HEALTH DEPARTMENT

NEW SUBSTANCES + WHAT PEOPLE ARE REPORTING

CLINICIANS AND PROVIDERS

CONTEXT FOR SYMPTOMS + EXPOSURE + CARE NEEDS

SEE THE DATA: STREETCHECK.ORG

Street Check is an innovative community-partnered project to standardize sample collection, analysis, and reporting for community drug checking programs.

The CUTS page on StreetCheck.org explains the study. It also gives people direct links to search sample results, access CUTS infographics, videos, printable resources, and sample collection information.

THANK YOU

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A Briefing on Selected 2026 Substance Use Disorder-Related Legislation

Joshua Miller, Senate Chairman Emeritus; Member, Governor's Overdose Task Force

Jacob E. Bissaillon, Senator; Rhode Island State Senate, District One

2026 RI General Assembly: Enacted Overdose-Response Legislation

Items passed by both chambers and signed into law

SIGNED / IN LAW | Prescribing standards | 988 crisis line | Youth MRSS | AI safety

OPIOID PRESCRIBING

Safer acute-pain opioid rules

Aligns state law with CDC guidance. Initial acute-pain opioid prescriptions limited to 7 days; minors require parent/guardian risk discussion and naloxone offer.

S 3259 Sub A / H 7923 Sub A

988 HOTLINE

Statutory authority and FY27 funding

Codifies Rhode Island's 988 Suicide & Crisis Lifeline and BHDDH administration. FY27 budget: $1.0M general revenue / $5.0M all funds.

FY2027 Budget, Article 10 § 9

YOUTH CRISIS RESPONSE

MRSS codified and reimbursed

Establishes statewide 24/7 Mobile Response and Stabilization Services for children and youth up to age 21; requires commercial reimbursement tied to the Medicaid MRSS rate.

S 3066 / H 8180 and S 3065 / H 7630

DIGITAL SAFETY

AI companion guardrails

Requires crisis-risk protocols, recurring user warnings, and Attorney General enforcement for AI companion models addressing self-harm or harm to others.

S 2195 / H 7350

2026 produced concrete gains in prevention, crisis access, youth stabilization, and technology safeguards.

Senate-Passed Priorities and Future Work

Policies that advanced but did not complete the full legislative process in 2026

PASSED SENATE ONLY

Access & Coverage

Pain alternatives *S 3022 Sub A*	Insurer plans for nonopioid medications and nonmedication pain management; RIDOH review and Medicaid MCO alignment.
MOUD without utilization review *S 2109 as amended*	Bars utilization review for medications to treat alcohol or opioid use disorder, including methadone, buprenorphine, and naltrexone.
No-cost buprenorphine *S 2034*	Requires coverage for at least one buprenorphine option in each form of administration without copay or deductible.
Kratom youth-access safety *S 2457 Sub A*	Requires kratom products to be stored in locked cases behind the counter.

HELD FOR STUDY

Future Consideration

Prior authorization limits	Would prohibit prior authorization for in-network mental health and substance use disorder services.
Mobile integrated healthcare	Would authorize RIDOH-regulated community paramedicine and related reimbursement.
EMS behavioral health response	Would allow licensed behavioral health/SUD providers to accompany EMS and support ER-diversion transport.

Continued focus: coverage, reimbursement, crisis-response infrastructure, and youth access.

Public Comment

RHODE ISLAND