State of Rhode Island

Amended Strategic Plan for Substance Abuse Prevention

2013-2015
Introduction

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is the single state authority for substance abuse prevention and treatment. BHDDH and its key stakeholders have developed the following strategic prevention plan. The purpose of this plan is to outline high priority goals and strategies to strengthen the infrastructure and to provide support at the State and community-level in service to the prevention and reduction of alcohol and drug abuse in Rhode Island (RI). The plan reflects ongoing efforts to use data and key stakeholder and community participation to set goals and objectives; prioritize evidence-based programs, practices, and policies; coordinate activities; determine key data indicators and evaluation plans to measure outcomes; identify target populations to reduce disparities related to substance use; and plan for the sustainability of infrastructures and activities. Ultimately, this plan should help to increase the overall readiness and capacity to carry out the activities associated with this plan. This document is meant to assist key stakeholders, prevention workforce members, and policy makers in providing a roadmap towards achieving the plan’s goals.

BHDDH utilizes the Strategic Prevention Framework (SPF) developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). The framework uses a five-step process known to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the life course. The SPF is built on a community-based risk and protective factors approach to prevention and a series of guiding principles appropriate for use here in RI at the State and community levels.

The idea behind SPF is to use the findings from public health research along with evidence-based prevention programs to build capacity across various geographies and populations, as well as the prevention field. This in turn will promote resilience and decrease risk factors in individuals, families, and communities.

The Strategic Prevention Framework Steps requires RI and its communities to systematically:

- Assess prevention needs based on epidemiological data,
- Build prevention capacity,
- Develop a strategic plan,
- Implement effective community prevention programs, policies and practices, and
- Evaluate efforts for outcomes.

Throughout all five steps, in is important to recognize that implementers of the SPF must address issues of sustainability and cultural competence.

There are several important features of the state’s prevention infrastructure that plays an important and distinct role in the substance abuse prevention system in Rhode Island. Each
feature supports the mission of BHDDH and has helped to provide strategic direction for this plan.

**Rhode Island's Governor's Council on Behavioral Health** - The Rhode Island Governor's Council on Behavioral Health is the mental health and substance abuse planning council. It reviews and evaluates mental health and substance abuse needs and problems in Rhode Island. It stimulates and monitors the development, coordination, and integration of statewide behavioral health services. The Council serves in an advisory capacity to the Governor.

**Rhode Island Prevention Resource Center (RIPRC)** - The RIPRC is a centralized training and technical assistance (TTA) resource for Rhode Island substance abuse prevention providers. The Center fosters state and local collaboration to prevent substance abuse and other risk-taking behaviors in Rhode Island.

**Rhode Island State Epidemiology Outcomes Workgroup (SEOW)** - The primary mission of the SEOW is to guide in institutionalized data-driven planning and decision making relevant to substance use/abuse and mental illness across Rhode Island. As such, the SEOW operates within the outcomes-based prevention framework, aiming to integrate prevalence and incidence data with risk and protective factors data into its decision-making process and policy-making at the state and community level.

**Rhode Island Student Assistance Services (RISAS)** - RISAS has been providing school and community-based substance abuse prevention and early intervention services to Rhode Island schools and communities since 1987.

**The Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP)** - The RIBCCDP defines a baseline standard for all credentials offered. Counselors are given recognition for meeting specific predetermined criteria in substance abuse. The RIBCCDP has been a participating member in the International Certification & Reciprocity Consortium (IC&RC) since 1988. (IC&RC sets international standards for counselor competency and develops and maintains written examinations for each reciprocal credential offered.)

**Rhode Island Substance Abuse Prevention Act (RISAPA)** - In 1987 the Rhode Island General Assembly passed the Rhode Island Substance Abuse Prevention Act (RISAPA) to promote comprehensive prevention programming at the community level. Thirty-five municipal task forces, covering all of the State’s 39 cities and towns, engage in local needs assessments; and planning, implementation, and evaluation of strategies, policies, and programs to produce long-term reductions in substance use and abuse.
RI Drug and Alcohol Treatment Association (DATA) - DATA is a nonprofit membership organization established in 1986 representing public and private alcohol and drug treatment, behavioral health, prevention and student assistant programs. Data promotes local, statewide and regional training initiatives in the interest of providing the best quality services to clients based on collaboration between behavioral health organizations. Additionally, they disseminate information related to the availability of community resources.

State Substance Abuse Prevention Priorities Based Upon the Epidemiological Profile

The most recent Rhode Island State Epidemiological Profile (Profile) was completed in 2013. The purpose of the 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. The profile provides a 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 across various populations (i.e., youth vs. adult);
- potential risk and protective factors associated with substance use and mental illness; and,
- mental and behavioral health outcomes

across the State of Rhode Island.

The profile is guided by an outcomes based prevention framework, and as such, it identifies the specific areas of need, as well as potential risk and protective factors from all ecological levels that helped to drive the strategic planning process.
Key findings from the profile include:

1. **SUBSTANCE USE:**

**ADVERSE CONSEQUENCES & CONSUMPTION PATTERNS**

**LONG and SHORT-TERM CONSEQUENCES OF SUBSTANCE USE**

- As evident from data shown in Table 1, several long-term adverse consequences remain elevated in Rhode Island, as compared to the national averages.

- This is especially the case for cardiovascular disease deaths, liver disease deaths, and chronic obstructive pulmonary disease deaths, whose rates remained greater in Rhode Island since 2000 through 2007.

- **Summary: Remaining a concern**

**Table 1.**
**RI vs. US Comparison on 14 indicators of adverse consequences of substance use (2000-2011).**

<table>
<thead>
<tr>
<th>Substance Use Consequence Indicators:</th>
<th>2000</th>
<th>2007</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RI</td>
<td>US</td>
<td>Ratio RI/U S</td>
</tr>
<tr>
<td>Liver Disease Death</td>
<td>0.15</td>
<td>0.12</td>
<td><strong>1.25</strong></td>
</tr>
<tr>
<td>Suicide Death</td>
<td>0.07</td>
<td>0.11</td>
<td><strong>0.66</strong></td>
</tr>
<tr>
<td>Homicide Death</td>
<td>0.04</td>
<td>0.06</td>
<td><strong>0.67</strong></td>
</tr>
<tr>
<td>Lung Cancer Death</td>
<td>0.58</td>
<td>0.56</td>
<td><strong>1.04</strong></td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease Death*</td>
<td>0.61</td>
<td>0.60</td>
<td><strong>1.01</strong></td>
</tr>
</tbody>
</table>
Note: Ratios greater than 1 indicate those consequences where RI exceeds the national average. All rates are per 1,000 population, except for data denoted with % (i.e., shown per 100 population).

### ALCOHOL and DRUG ABUSE/DEPENDENCE DSM-IV DIAGNOSES

### MARIJUANA and ILLICIT DRUG USE

- As evident from data shown in Table 1, both alcohol and drug-related Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnoses increased from 2000 to 2007. This was true for both RI and the US as a whole.

- However, Table 2 and Table 3 shows that, while the alcohol-related diagnoses in Rhode Island remained closer to the national trends by 2007, the rates of drug-related diagnoses in Rhode Island have more than doubled since 2000, and in 2007 have exceeded the national average by almost 60%.

- Similarly, as shown in Table 4, underage marijuana use – even though there was a decreasing trend from 2001 to 2009 – remained the only underage substance use...
consumption indicator with prevalence greater in Rhode Island than in the rest of the country.

- At the same time, related to these increasing trends in drug-related diagnoses, Table 5 documents doubling of the illicit drug use among persons older than 12 years of age in Rhode Island, from 3.0% in 2000 to 5.9% in 2007-2008, resulting in an 64% greater illicit drug use in Rhode Island in 2007-2008 than in the rest of the nation.

- **Summary: Increasing and great concern**

Table 2.
**DSM-IV Alcohol Abuse or Dependence Diagnosis (%); Time-trend.**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>RI</td>
<td>6.4</td>
<td>10.1</td>
<td>9.6</td>
<td>7.8</td>
<td>9.1</td>
</tr>
<tr>
<td>US</td>
<td>5.5</td>
<td>7.6</td>
<td>7.6</td>
<td>7.4</td>
<td>6.8</td>
</tr>
</tbody>
</table>

| RI/US Ratio | 1.15 | 1.33 | 1.25 | 1.04 | 1.33 |

Note: Ratios greater than 1 indicate that RI exceeds the national average.

Table 3.
**DSM-IV Drug Abuse or Dependence Diagnosis (%), Time-trend.**

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>RI</td>
<td>1.9</td>
<td>3.9</td>
<td>3.5</td>
<td>4.4</td>
<td>2.8</td>
</tr>
<tr>
<td>US</td>
<td>2.0</td>
<td>3.0</td>
<td>3.0</td>
<td>2.8</td>
<td>2.7</td>
</tr>
</tbody>
</table>

| RI/US Ratio | .96  | 1.32 | 1.17 | 1.59 | 1.04 |

Note: Ratios greater than 1 indicate that RI exceeds the national average.
Table 4.  
RI vs. US comparison on nine key Consumption Indicators for underage population (<18), 2001-2011.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>RI</td>
<td>US</td>
<td>Ratio</td>
<td>RI</td>
<td>US</td>
<td>Ratio</td>
<td>RI</td>
<td>US</td>
<td>Ratio</td>
<td>RI</td>
<td>US</td>
<td>Ratio</td>
</tr>
<tr>
<td>Alcohol use past month</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol use past month</td>
<td>50.3</td>
<td>47.0</td>
<td>1.07</td>
<td>34.0</td>
<td>41.8</td>
<td>.81</td>
<td>30.0</td>
<td>38.7</td>
<td>.78</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Binge drinking past month</td>
<td>30.7</td>
<td>29.9</td>
<td>1.02</td>
<td>18.7</td>
<td>24.2</td>
<td>.77</td>
<td>18.3</td>
<td>21.9</td>
<td>.84</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial use of alcohol before age 13</td>
<td>29.7</td>
<td>29.1</td>
<td>1.02</td>
<td>15.8</td>
<td>21.1</td>
<td>.75</td>
<td>15.6</td>
<td>20.5</td>
<td>.76</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drinking and driving past month</td>
<td>15.5</td>
<td>13.3</td>
<td>1.16</td>
<td>7.2%</td>
<td>9.7%</td>
<td>.74</td>
<td>6.5%</td>
<td>8.2%</td>
<td>.79</td>
<td></td>
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</tr>
<tr>
<td>In car w/ driver who had been drinking (past month)</td>
<td>32.3</td>
<td>30.7</td>
<td>1.05</td>
<td>23.1</td>
<td>28.3</td>
<td>.82</td>
<td>21.9</td>
<td>24.1</td>
<td>.90</td>
<td></td>
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<tr>
<td>Cigarette use</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Smoking cigarettes 20 + days past month</td>
<td>14.2</td>
<td>13.8</td>
<td>1.03</td>
<td>5.4%</td>
<td>7.3%</td>
<td>.74</td>
<td>4.4%</td>
<td>6.4%</td>
<td>.69</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial use of tobacco before age 13</td>
<td>22.3</td>
<td>22.1</td>
<td>1.01</td>
<td>8.4%</td>
<td>10.7%</td>
<td>.79</td>
<td>7.1%</td>
<td>10.3%</td>
<td>.69</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana use</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Using marijuana past month</td>
<td>33.2</td>
<td>23.9</td>
<td>1.38</td>
<td>26.3</td>
<td>20.8</td>
<td>1.26</td>
<td>26.3</td>
<td>21.3</td>
<td>1.23</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
### Table 5.
RI vs. US Comparison on five key Consumption Indicators, 2000-2008.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial use of marijuana before age 13</td>
<td>12.8%</td>
<td>10.2%</td>
<td>1.25</td>
</tr>
<tr>
<td>Prescription drug misuse past year</td>
<td>--</td>
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</tr>
</tbody>
</table>

Note:
Ratios greater than 1 indicate those consumption patterns where RI exceeds the national average. Ratios smaller than 1 indicate those consumption patterns where RI is lower than the national average.

**Consumption Indicators:**
- Driving when “Perhaps Had too Much to Drink” past month
- Heavy drinking past month
- Binge drinking past month

**% of Adults (aged 18+) Reporting:**
- Driving when “Perhaps Had too Much to Drink” past month:
  - RI: 4.5%
  - US: 4.8%
  - RI/US: 0.93
  - RI: 7.3%
  - US: 5.9%
  - RI/US: 1.24
  - RI: 23.8%
  - US: 27.8%
  - RI/US: 0.85

**% of Individuals aged 12+ Reporting:**
- Heavy drinking past month:
  - RI: 7.1%
  - US: 5.2%
  - RI/US: 1.36
  - RI: 6.7%
  - US: 6.6%
  - RI/US: 1.01
UNDERAGE SMOKING AND DRINKING

- As evident from data shown in Table 4 underage alcohol and cigarette use has considerably decreased from 2001 to 2009, such that the prevalence of most indicators of underage drinking and smoking among Rhode Island underage population is now roughly 20-25% below national averages.

- For example, in 2009, only 15.8% of Rhode Island youth reported initiating alcohol use before age 13, compared to 21.1% of all US youth.

- Even though the national trends in underage drinking and smoking also declined in this time period, reduction in these consumption trends was greater for Rhode Island.

- For example, in 2001, 29.7% of Rhode Island youth and 29.1% of all US youth reporting initiating drinking before the age of 13, while in 2011 only 15.8% of Rhode Island and 21.1% of all US youth reported such an early initiation age.

- **Summary:** Significant progress, improving trends
2. RISK & PROTECTIVE FACTORS:

ECONOMIC, CRIMINAL JUSTICE, SCHOOL ENVIRONMENT & SPECIAL POPULATION INDICATORS

- As evident from data shown in Rhode Island compared favorably to the rest of the nation in school- and special-population protective indicators.

- However, unemployment rate in Rhode Island is one of the highest in the nation, exceeding national averages by 21% in 2010.

- Summary: Additional years of data needed

3. GENERAL MENTAL HEALTH:

DEPRESSION AND SUICIDE-RELATED OUTCOMES

As evident from the selected indicators shown in Table 6, Rhode Island was comparable to the rest of the nation in terms of depression symptomatology and suicide-related outcomes.

- However, youth suicide attempts in Rhode Island exceeded national averages by 22% in 2009.

- Summary: Additional years of data needed
Table 6.  
RI vs. US Comparison on General Mental Health Indicators.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Year</th>
<th>RI</th>
<th>US</th>
<th>Ratio RI/US</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Population</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current depression symptoms (adults)</td>
<td>2006</td>
<td>9.0%</td>
<td>9.0%</td>
<td>1.0</td>
</tr>
<tr>
<td>Post-partum depression symptoms</td>
<td>2005</td>
<td>14.1%</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Suicide Deaths</td>
<td>2007</td>
<td>0.06</td>
<td>0.11</td>
<td>0.59</td>
</tr>
<tr>
<td><strong>Youth Population</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt sad/hopeless almost every day for 2+ weeks in a row in past year</td>
<td>2009</td>
<td>25.0%</td>
<td>26.1%</td>
<td>0.96</td>
</tr>
<tr>
<td>Youth suicidal ideation</td>
<td>2009</td>
<td>11.8%</td>
<td>13.8%</td>
<td>0.86</td>
</tr>
<tr>
<td>Youth suicidal plans</td>
<td>2009</td>
<td>11.3%</td>
<td>10.9%</td>
<td>1.04</td>
</tr>
<tr>
<td>Youth suicide attempts</td>
<td>2009</td>
<td>7.7%</td>
<td>6.3%</td>
<td>1.22</td>
</tr>
</tbody>
</table>

Note:
Ratios greater than 1 indicate mental health indicators where RI exceeds the national average.
Snapshot of State and Community Level Prevalence Rates

Populations of Focus:
Using the Strategic Prevention Framework, RI has identified underage drinking and marijuana use among youth 12 – 17 in twelve (12) Rhode Island communities as high need.

Alcohol Target Communities include: Burrillville, Cranston, Foster, Johnston, New Shoreham, Newport, Providence, and Westerly.

Marijuana Target Communities include: Cumberland, Foster, Johnston, Lincoln, Little Compton, New Shoreham, Newport, and Scituate.

Because these 12 communities comprise 45% of the state’s population and they are communities with the highest prevalence rates, it is expected that changes in youth prevalence in these communities will lead to statewide reductions in the use of these substances. Furthermore, these communities contain high proportions of minority residents and have poverty levels over twice those of other communities. It is important to recognize subpopulations with the highest growth in the state during the past decade, as well as subpopulations impacted by health disparities.

Rhode Island is geographically the smallest US state, located in the New England region of the Northeast bordered by Massachusetts on the north and east and Connecticut on the west. The 2010 Census estimates its population at 1,052,567, with the majority of the population being white, non-Hispanic and over 20 years of age (Figure 1). In fact, RI is highly comparable to the entire U.S. population in terms of gender (48% male in RI vs. 49% for the U.S.) and for age distribution. 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 .4% from 2000 to 2010. Although this statewide population growth was minimal, the racial-ethnic composition of Rhode Island changed, such that between 2000 and 2010, Hispanic and non-Hispanic black populations increased from 8.7% to 12.4% and from 4.8% to 5.7%, respectively. Unemployment and poverty levels, which may contribute as social factors to substance use, remain quite high in Rhode Island and among the top in the nation. Unemployment is 9.1% (compared to the national average of 7.6%) and the poverty level is estimated at 12.8% of the population (2007-2011) compared to 14.3% nationally.
Table 7 below provides demographic summary data for all of Rhode Island, the 12 high need communities that we have identified to be sub-recipient communities in Rhode Island’s SPF PFS initiative, and the remaining municipalities. Eight communities were identified as being at high risk for elevated levels of youth alcohol use. These communities had high proportions of minority residents, approximately twice the values of the state as a whole. Poverty levels for these communities (21.1%) were over twice that of the remaining municipalities (9.4%). In contrast, the eight communities identified as having high levels of youth marijuana use had predominately White residents (proportion Latino and Black/African American being less than half of state average) and poverty levels (9.2%) well below the state average (15.2%).
Table 7.
Demographics of Rhode Island, the 12 Target Communities, and All Else in 2010.

<table>
<thead>
<tr>
<th></th>
<th>Rhode Island (n = 12)</th>
<th>All High Need Target Communities (n = 12)</th>
<th>Remaining Communities (n=27)</th>
<th>Alcohol Target Communities (n=8)</th>
<th>Marijuana Target Communities (n=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Population under 18</td>
<td>21.3</td>
<td>21.7</td>
<td>20.1</td>
<td>21.6</td>
<td>20.3</td>
</tr>
<tr>
<td>% Non-White</td>
<td>18.6</td>
<td>27.6</td>
<td>7.5</td>
<td>31.7</td>
<td>8.8</td>
</tr>
<tr>
<td>% Latino</td>
<td>12.4</td>
<td>19.7</td>
<td>3.2</td>
<td>22.8</td>
<td>5.0</td>
</tr>
<tr>
<td>% African American</td>
<td>5.7</td>
<td>8.5</td>
<td>2.0</td>
<td>9.9</td>
<td>2.5</td>
</tr>
<tr>
<td>% Asian</td>
<td>2.9</td>
<td>4.4</td>
<td>1.8</td>
<td>4.8</td>
<td>1.9</td>
</tr>
<tr>
<td>% Males aged 15-34</td>
<td>13.7</td>
<td>15.4</td>
<td>12.2</td>
<td>16.3</td>
<td>11.9</td>
</tr>
<tr>
<td>% Below poverty level (2009)*</td>
<td>15.2</td>
<td>18.6</td>
<td>9.4</td>
<td>21.1</td>
<td>9.2</td>
</tr>
</tbody>
</table>

*Data from City-Data.com, not available from Census 2010

Table 8 provides a snapshot of levels of alcohol and illicit drug use for the 12 communities that we have targeted for this work, for the remaining communities, and for all of Rhode Island. As expected, the 8 communities that have been targeted due to concerns regarding underage drinking show higher levels on measures of youth drinking – for example, in 2012 8.9% of middle school students reported lifetime drinking compared to 7.5% for all of RI. Similarly, where levels of moderate drinking have decreased 52% from 1999 – 2011 in RI, these 8 target communities evidenced only a 20.5% reduction and one showed an increase.
Table 8.
Levels of Youth Substance Use in Rhode Island, the 12 Target Communities, and Remaining Communities.

<table>
<thead>
<tr>
<th></th>
<th>Rhode Island (n=39)</th>
<th>12 Target Communities</th>
<th>All Else (n=27)</th>
<th>Alcohol Target Communities (n=8)</th>
<th>Marijuana Target Communities (n=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High School Students</strong></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>% Moderate Alcohol Use 2011</td>
<td>9.7</td>
<td>11.2</td>
<td>9.3</td>
<td>11.7</td>
<td>11.1</td>
</tr>
<tr>
<td>Average % Moderate Alcohol Use 1999-2011</td>
<td>18.7</td>
<td>17.4</td>
<td>18.6</td>
<td>19.3</td>
<td>20.9</td>
</tr>
<tr>
<td>% Change Moderate Alcohol Use 1999-Recent</td>
<td>-52.2</td>
<td>-30.3</td>
<td>-63.0</td>
<td>-20.5</td>
<td>-25.0</td>
</tr>
<tr>
<td>% Moderate Illicit Drug Use 2008</td>
<td>21.8</td>
<td>23.6</td>
<td>21.5</td>
<td>22.4</td>
<td>25.9</td>
</tr>
<tr>
<td>Average % Moderate Illicit Drug Use 1999-2008</td>
<td>22.7</td>
<td>23.2</td>
<td>23.1</td>
<td>22.8</td>
<td>25.0</td>
</tr>
<tr>
<td>% Change Moderate Illicit Drug Use 1999-2008</td>
<td>+10.6</td>
<td>-1.0</td>
<td>+16.3</td>
<td>+9.5</td>
<td>-7.4</td>
</tr>
<tr>
<td>Under influence of drugs at school 2011</td>
<td>15.1</td>
<td>16.4</td>
<td>14.4</td>
<td>16.4</td>
<td>15.9</td>
</tr>
<tr>
<td><strong>Middle School Students</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Current Alcohol Use 2012</td>
<td>7.5</td>
<td>7.8</td>
<td>6.3</td>
<td>8.9</td>
<td>8.8</td>
</tr>
<tr>
<td>% Ever Marijuana Use 2012</td>
<td>4.9</td>
<td>5.0</td>
<td>4.4</td>
<td>5.4</td>
<td>4.9</td>
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Prevention in the Context of a Changing Political Landscape

In June 2012, Rhode Island Governor Lincoln Chafee signed legislation to replace the criminal penalties for adults’ possession of up to an ounce of marijuana with a civil violation of $150 for most violations. The legislation went into effect on April 1, 2013.

Additionally, in May 2012, a year after halting implementation of the compassion center program citing fears of federal interference, Governor Chafee signed legislation that was written to alleviate his concerns and allows the compassion centers to open. Two compassion centers opened in Spring of 2013.

Prevention in the context of these laws needs to be thoughtful and consider the increasing rates of drug use among Rhode Island youth. For example, Rhode Island has an opportunity to apply the lessons the country has learned about how alcohol and tobacco advertising has affected children.

One recommendation is to consider banning all marketing and advertising activities of Rhode Island’s marijuana dispensaries and to extend that policy to other sellers if marijuana is legalized for recreational use. Legislation, regulations and policies can prevent or reduce marijuana use among RI youth.

From a prevention perspective Rhode Island legislators and policy makers must ensure that all current and proposed marijuana-related legislation, regulations and policies:

- Incorporate clear enforceable safeguards that reduce both perceived availability and the risk of access by youth.
- Include programs and funding to communicate the message that adolescent marijuana use can have harmful and lasting effects on physical, mental and emotional health.

Opportunities for Enhanced Infrastructure and Assessment Findings

Rhode Island has documented both strengths and weaknesses of its current substance abuse prevention and treatment system throughout this plan. Opportunities exist to explore enhanced infrastructure to increase awareness and capacity among stakeholders within the system, while creating greater integration and efficiencies of the system as whole.

It is important to explore potential opportunities to reduce redundant efforts and align resources to be more cost effective. Increased and effective communication strategies across all sectors will help to facilitate collaboration and promote existing services and infrastructure. This includes greater integration among prevention and mental health promotion across behavioral health provider systems and sectors.

There is a need to have greater surveillance of current or existing providers to better understand the varying levels of readiness and capacity to affect change. A clear opportunity exists to improve workforce development strategies to increase the capacity, knowledge, skills and organizational development of prevention and mental health promotion providers driven by
sound practice and data-driven program planning. This includes greater participation in the RI Substance Abuse Prevention Certification System. Additionally, on-going assessments should be conducted to evaluate and sustain RI’s prevention and mental health promotion system.

One key success for Rhode Island includes its efforts to fundamentally transform its prevention infrastructure. BHDDH based this transformation, in part, upon empirical results generated from Rhode Island’s SPF-SIG grant. Using data from Rhode Island community coalitions, Nargiso and colleagues (Nargiso et al., 2012) found that community coalitions which endorsed weaker mobilization, structure and task leadership utilized more Training and Technical Assistance (TTA) offered during the Strategic Prevention Framework State Incentive Grant (SPF-SIG) compared to those who perceived their coalition as having greater capacity. Moreover, communities that utilized more TTA resources produced a greater number of successful policy changes in municipal and school policies relating to underage drinking. These findings led BHDDH to fund the Rhode Island Prevention Resource Center (RIPRC) with Prevention Block Grant funds.

RIPRC is a statewide, central information sharing and training and technical assistance (TTA) resource for all Rhode Island state and community-based substance abuse prevention services and their community partners. In order to effectively target TTA resources, the RIPRC collected baseline training and technical assistance needs and organizational capacity information in the winter of 2012. Fifty (50) organizations engaged in substance abuse prevention activities were invited to complete the TTA needs assessment survey that asked about a variety of TTA topics including: organizational capacity to build effective coalitions, monitoring and evaluation, ability to offer evidence based programs and practices, ability to implement evidence-based policies, cultural competency, understanding of the Strategic Prevention Framework, knowledge of target populations, and program management. A total of thirty-five (35) unique providers completed the needs assessment survey, a seventy percent (70%) response rate. The complete report of the survey findings is available in Attachment 1.

In the RIPRC needs assessment, prevention providers identified eight (8) training content areas needed to increase the capacity of communities to implement, sustain and improve effective prevention initiatives, content areas including: Public Policy and Environmental Change (43%), Prevention Policy Development (37%), Ethics and Confidentiality (37%), Sustainability Planning (34%), Survey Development and Use (31%), Navigating Political Systems (31%), Using Survey Data for Planning and Proposals (29%) and Implementing Focus Groups (29%). The following six (6) key technical assistance needs were also identified: Increasing the Prevention Expertise of Coalition Members (49%), Maximizing Social Media Tools for Prevention (43%), Implementing and Using Needs Assessments (40%) Using Data for Program Improvement (29%), Engaging Key Stakeholders (29%) and Utilizing Asset Building Multidisciplinary Programming (26%).
RIPRC’s TTA work plan and deliverables are based on the needs assessment data and focus on an environmental approach to prevention that captures substance use and abuse, but also works to reach the complementary goals of reducing the burden of mental, emotional, and behavioral disorders and promoting healthy development of children and young people in Rhode Island. Having a findings-based work plan serves to avoid duplication of services, improve access to training opportunities, and increase participation in the RI Substance Abuse Certification Process.

One of the primary areas of the plan includes activities to increase participation in the RI Substance Abuse Prevention Certification System, while building on the current substance abuse prevention infrastructure to both expand and increase the capacity of the prevention workforce in RI. The RI Substance Abuse Prevention Certification Process is currently under-utilized. The primary benefits of certification for individuals and organizations identified by assessment participants includes: meeting the requirements of BHDDH funding, that it documents prevention expertise, and gives the ability to apply for additional state and federal funding opportunities. The primary barriers to achieving RI Prevention Certification include: the process takes too long, collecting required documents is difficult, not sure if the certification is worth the investment and test aversion. Under the “other” write-in answer choice for barriers, survey respondents indicated that, limited prevention trainings, not enough RI-based trainings, and [a process that is] too complicated were barriers to certification.

A core function of the RIPRC is to promote local, state, regional and national training and other learning opportunities that meets certification requirements. Training sessions should be available in multiple modes, face-to-face, online courses, webinars, etc. Technical assistance may also be documented to meet the RI certification requirements. Currently, prevention providers may use BHDDH funding to pay for certification fees. Providers need to be reminded to use their current funding to pay for certification fees and training. The identification of additional funding sources and/or scholarships is important to increase access to training and increase the number of providers who are Certified Prevention Specialists in Rhode Island.

In addition to the certification issues presented above, the needs assessment survey respondents focused primarily on substance abuse prevention content areas. Funding, sustainability and environmental strategies are identified as the main areas of need. Therefore the connection between broader prevention content areas and environmental strategies would benefit RI prevention providers. However, much of the current prevention funding in RI is focused on substance abuse prevention. Stronger, measurable and sustainable connections between complementary prevention initiatives, including: violence prevention, sexual health, etc. will be a focus of the RIPRC training and technical assistance initiatives. Rhode Island has identified the need to create an integrated infrastructure in order to more effectively guide and support the administration of substance abuse prevention and mental health.
promotion services across the state. The following strategic planning goals and objectives serve to ensure that strategies and activities selected for implementation will meet the needs identified during the assessment phase of the planning effort. The Rhode Island Prevention Advisory Committee (PAC), which reports to the Governor’s Council on Behavioral Health, has been identified as body responsible for to providing a forum to coordinate the State’s strategic efforts to reduce the incidence and prevalence of alcohol, tobacco and other drug (ATOD) misuse and abuse as well as provide leadership and continuity in advancing ATOD prevention and mental health promotion (MHP) for RI residents. The PAC also will assist BHDDH and the Governor’s Council in attaining sustainable outcomes, reinforcing collaborative efforts, reducing redundancies, and aligning the state’s resources to achieve objectives outlined in the RI Prevention Strategic Plan.

STRATEGIC PLANNING GOALS AND OBJECTIVES

SYSTEM-LEVEL AWARENESS AND CAPACITY:

**Goal One:** Improve the awareness and capacity to integrate prevention and mental health promotion across behavioral health provider systems and sectors.

**Objective I:** By August 2014 (and each year thereafter), BHDDH will document the surveillance of current providers for prevention and mental health promotion on the state and community level(s) to ensure contractual deliverables are being met and document the integration of behavioral health across prevention initiatives through the production of an annual summary report presented to the Rhode Island Prevention Advisory Committee PAC and to the Governor’s Council on Behavioral Health. The summary report will document the integration of mental health promotion and alcohol, tobacco and other drug (ATOD) initiatives across the following state and community level organizations:

a) State-level:
   1. URI, Statewide Evaluation Contract
   2. State Epidemiology Outcomes Workgroup (SEOW)
   3. RI Prevention Resource Center (RIPRC)

b) RI Substance Abuse Prevention Act (RISAPA) Grantees

c) Marijuana and Other Drug Initiative (MOD) Grantees

**Objective II:** By December 31st, 2015 maintain a consistent and regular schedule of behavioral health group meetings. Each meeting will specifically identify opportunities to address the following: 1) to increase communication across the sectors; 2) to identify increased opportunities for collaboration; and 3) to ensure promotion of existing services and initiatives.
Meetings will include and meet as follows:

a) Governor’s Council on Behavioral Health: Monthly  
b) SEOW: Quarterly  
c) IC & RC Prevention Certification Boards: Quarterly  
d) PAC: Quarterly  
e) RISAPA: Grantees: Monthly  
f) RIPRC: Biweekly  
g) MOD Quarterly  

**Objective III**: By December 31st, 2015 BHDDH (directly or through a contract) will provide a minimum of 4 to 6 on-line or face-to-face trainings and a minimum of 20 to 30 technical assistance opportunities annually.

The purpose of the TTA opportunities is to increase the capacity of providers to integrate prevention and mental health promotion to decrease silos, increase cross-sector collaboration and plan, implement, evaluate and sustain comprehensive, culturally competent and relevant strategies.

**Goal Two**: Convene a Rhode Island Prevention Advisory Committee (PAC) as a committee of the RI Governor’s Council on Behavioral Health, to provide guidance to support the administration of substance abuse prevention and mental health promotion services across the state.

**Objective I**: By December 31st, 2015 recruit a minimum of 15 professionals representing a broad range of content expertise (refer to list below) to the PAC.

The purpose of the PAC is to coordinate the State’s strategic efforts to reduce the incidence and prevalence of ATOD misuse and abuse, as well as provide leadership and continuity to advance ATOD prevention and mental health promotion (MHP).

1) BHDDH Prevention and Planning Unit*  
2) Department of Health (HEALTH) and/or Community Violence Prevention and/or Suicide Prevention *  
3) RI Substance Abuse Prevention Act (RISAPA) *  
4) Mental Healthcare  
5) Certified Prevention Specialist*  
6) Student Assistance Program *  
7) State Epi Outcomes Workgroup (SEOW) *  
8) Department of Youth and Family Services Prevention Specialist/Family Community Care Partnership Representative(s)  
9) Military Prevention  
10) School-based Healthcare
12) Community/School Health Educator (s)
13) Physical Healthcare Provider (s)
14) Parent Organization
15) Law Enforcement
16) Tobacco Control Prevention Specialist (s)
17) Recovery and Treatment
18) Developmental Disabilities
19) RI Department of Education
20) Youth Organizations
21) Mental Health Promotion

Please note: sectors followed by an asterisks (*) are required representatives.

**Objective II:** By March 31st, 2014, the RI Prevention Advisory Committee will meet on a quarterly basis specifically to 1) review current prevention research; 2) review ATOD Prevention/MHP policy updates; 3) develop new ATODP/MHP policies (as needed); and, 4) disseminate quarterly meeting notes and action items.

This will be accomplished by developing and reviewing strategic planning to ensure inclusion of prevention initiatives in the Governor’s Council on Behavioral Health recommendations, serve as an expert panel for state and community programming and report on prevention initiatives to the Governor’s Council on Behavioral Health.

**Objective III:** By December 31st, 2015 the RI Prevention Advisory Committee will assist BHDDH and the Governor’s Council on Behavioral Health to document the deliverables outlined in the RI Strategic Plan for Substance Abuse Prevention in a written annual report.

The purpose of the report is to document sustainability outcomes, reinforce collaborative efforts, reduce redundancies, and align the state’s resources to achieve specific collective objectives outlined in the current RI Strategic Plan for Substance Abuse Prevention.

**SYSTEM CAPACITY & SUSTAINABILITY:**

**Goal Three:** Evaluate and sustain RI prevention and mental health promotion system.

**Objective I:** By December 31st, 2014 (and for each year after) BHDDH will develop an annual report utilizing prevention data to analyze and report on process and outcome measures to determine the effectiveness of the state’s prevention and mental health promotion system and to make recommendations for improvement.
**Objective II:** By December 31st, 2015 BHDDH will develop a sustainability plan (to begin implementation in January of 2016) to specifically outline prevention and mental health promotion programming, policies and initiatives.

**Objective III:** By July 1, 2014, BHDDH will assess, in collaboration with community providers, the feasibility of implementing regional prevention provider networks to examine its potential cost-effectiveness and sustainability as a population-based prevention system strategy.

**LOCAL CAPACITY BUILDING:**

**Goal Four:** Based on the current epidemiology and community profiles provided by the State Epidemiology Outcomes Workgroup (SEOW), community-based needs assessment data, and State youth and adult behavioral health data, improve outcome focused processes across prevention and mental health promotion providers.

**Objective I:** By December 31st, 2015 increase the number of RISAPA grantees who are actively (not expired) Certified Prevention Specialists (CPS) or Certified Prevention Specialist Supervisors (CPSS) from 26% (as of 12/05/13) to 75%.

Having a greater number of CPS will help to meet workforce development goals to increase the capacity, knowledge, skills and organizational development of prevention and mental health promotion providers to address complex ATOD problems and consequences, as well as, self-harming and adverse behavioral health consequences.

**Objective II:** By December 31st, 2014 (and for each year after) BHDDH will ensure the RI Prevention Resource Center, RI substance abuse providers, and Drug-Free Community Grantees and other prevention providers collect data, report data, and identify data-driven program planning in their reporting according to the following:

- RISAPA Grantees – Monthly Reporting
- Drug-Free Community Grantees – Quarterly Reporting
- MOD Grantees – Quarterly Reporting
- RIPRC – Quarterly Reporting and Annual Report

**Objective IIa:** By December 31st, 2014 state/regional/locally funded prevention providers will select a minimum of 2 of SAMHSA’s Prevention and Substance Abuse and Mental Illness goals (presented below) in the development of program planning and will utilize State and local data to inform these data-driven programmatic planning activities in their reporting.
SAMHA’s 2011-2014 Prevention goals include:

Goal 1.1: With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.

Goal 1.2: Prevent or reduce consequences of underage drinking and adult problem drinking.

Goal 1.3: Prevent suicides and attempted suicides among populations at high risk, especially military families, LGBTQ youth, and American Indians and Alaska Natives.

Goal 1.4: Reduce prescription drug misuse and abuse.