ABSTRACT

The Rhode Island Strategic Prevention Framework Partnerships for Success (SPF-PFS) project will enhance our current underage drinking efforts with youth ages 12-17. Our additional priorities will be to reduce marijuana use among youth 12-17 and assess prescription drug use and misuse among youth and young adults ages 12-25 and the resultant burden.

We will fund subrecipients in twelve Rhode Island communities of high need. These twelve sub-recipient communities comprise a large percentage of the state's population, and we anticipate state-wide reductions in the use of these substances.

We will continue the work of the State Epidemiological Outcomes Workgroup (SEOW) to institutionalize data-driven decision making for state and community level prevention planning and to integrate behavioral health indicators such as preventing mental illness and promoting positive mental health as it relates to substance abuse. This initiative will also address the need to assess and learn how State Epidemiologic and Outcome Workgroups have influenced state and community prevention planning.

This five-year proposal seeks to continue and extend work that has been conducted in partnership between Brown University, University of Rhode Island, JSI/Prevention Resource Center (PRC) and the State of Rhode Island.

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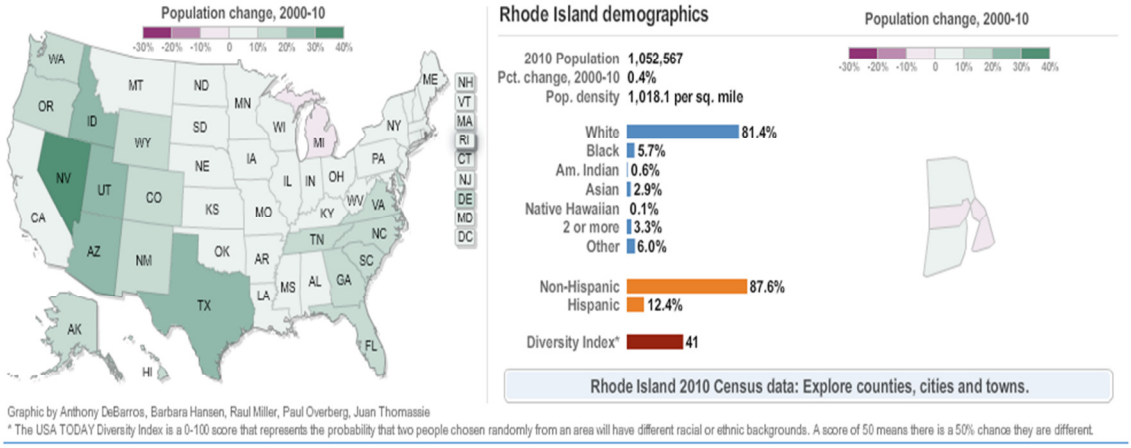
SECTION A: STATEMENT OF NEED

A.1 Populations of Focus:

The Rhode Island Strategic Prevention Framework Partnerships for Success (SPF PFS) grant will target underage drinking and marijuana use among youth 12 – 17 in twelve (12) Rhode Island communities of high need. Because these 12 subrecipient 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, several subrecipient communities contain high proportions of minority residents and have poverty levels over twice those of other communities. In this way, the RI SPF PFS grant will focus on 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 ethnically/racially White and over 20 years of age. 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 the national value of 14.3%.



A.2 Snapshot of State and Community Level Prevalence Rates

Data presented in Section B justify our selection of underage drinking and marijuana use among youth aged 12 – 17 as our priorities. We also provide a detailed description of how we have selected 12 of the 39 municipalities in RI as our priority communities in Section B. Here, Table 1 below provides a 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 8 communities identified as having high levels of youth marijuana use had predominately Caucasian residents (proportion Latino and African American less than half of state average) and poverty levels (9.2%) well below the state average (15.2%).

Table 1. Demographics of Rhode Island, the 12 Target Communities, and All Else in 2010.

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

*Data from City-Data.com, not available from Census 2010Table 2 provides a snapshot of levels of alcohol and illicit drug use for the 12 communities that we have tentatively 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). Some of these differences may appear more modest thatn anticipated. This results from our decision (based on fundamental psychometric principles) to use multiple indices that often do not track in parallel (rather than single indices) to target communities.

Table 2. Levels of Youth Substance Use in Rhode Island, the 12 Target Communities, and Remaining Communities.

	Rhode Island (n=39)	12 Target Communities	All Else (n=27)	Alcohol Target Communities (n=8)	Marijuana Target Communities(n=8)
High School Students					
% Moderate Alcohol Use 2011	9.7	11.2	9.3	11.7	11.1
Average % Moderate Alcohol Use 1999-2011	18.7	17.4	18.6	19.3	20.9
% Change Moderate Alcohol Use 1999-Recent	-52.2	-30.3	-63.0	-20.5	-25.0

% Moderate Illicit Drug Use 2008	21.8	23.6	21.5	22.4	25.9
Average % Moderate Illicit Drug Use 1999-2008	22.7	23.2	23.1	22.8	25.0
% Change Moderate Illicit Drug Use 1999-2008	+10.6	-1.0	+16.3	+9.5	-7.4
Under influence of drugs at school 2011	15.1	16.4	14.4	16.4	15.9
Middle School Students					
% Current Alcohol Use 2012	7.5	7.8	6.3	8.9	8.8
% Ever Marijuana Use 2012	4.9	5.0	4.4	5.4	4.9

A.3 Need for Enhanced Infrastructure / Gaps in Resources / Stakeholders and Resources

Rhode Island is energetically engaged in a fundamental transformation of its prevention infrastructure. The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (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 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. (Notably, only four of the twelve high need communities identified for this grant were part of the SPF-SIG). 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 (RI) 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 2.

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 will 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.

The RIPRC adds another piece to the many long-standing, committed stakeholders led by BHDDH. BHDDH has an extensive number of current prevention providers. (BHDDH requires funded providers to verify workforce development via the Rhode Island Certification Process and currently more than half of prevention providers are certified). BHDDH's Student Assistance Programs provide individual strategies through problem identification and referral in 44 middle and high schools statewide. The 35 RI Substance Abuse Prevention Act (RISAPA) coalitions cover all 39 municipalities and perform local needs assessments. They plan, implement and evaluate strategies, policies and programs to produce long-term reductions in substance use and abuse. We have a network of providers through our Reducing Marijuana and Other Drug Initiative where they collaborate with local prevention coalitions and implement evidence based prevention interventions in their local high schools with both the general population of youth and with those at high or highest risk for abuse of marijuana and other illicit drugs. The Governor's Council on Behavioral Health is the state's behavioral health planning council. Its purpose is to advise the Governor and General Assembly on policies, goals and operations of the behavioral health program, including areas of substance abuse and mental health, and on matters that BHDDH refers to the Council. It will be instrumental in the development and coordination of new prevention strategies. The Enforcing Underage Drinking Advisory Committee is the state's policy advisory group, which includes youth, law enforcement and public education subcommittees. The Advisory Committee was instrumental in the development and review of a statewide underage drinking prevention logic model and monitors its implementation. We continue to have a collaborative relationship with the Rhode Island Department of Elementary and Secondary Education. We previously were partners on the Building State Capacity grant where we vetted our prevention strategic plan. Also, we have been able to get their approval and assistance in administering the Rhode Island Student Survey in several high schools and hope to conduct statewide in 2014. We work closely with The Department of Health on both their Suicide Prevention Subcommittee and Youth Risk Survey. Both Education and Health serve as members of the State Epidemiological Outcomes Workgroup. Furthermore, the University of Rhode Island Department of Psychology Community Research and Services Team (CRST) provides technical assistance and expert consultation to BHDDH and programs funded by BHDDH regarding process and outcome evaluation. This past winter the CAPT and BHDDH agreed on the next year's work plan which will focus on convening an evidence based program panel to help Rhode Island increase the use of evidence based practices.

A.4 SEOW Expansion and Enhancement

Rhode Island has continued the work of the SEOW through a subcontract with Synectics. This work has included expansion of the scope of the SEOW to include children's mental health and young adult behavioral health. Through this grant award, the work of the SEOW will be enhanced through additional data analysis personnel supported by the award. This will include

both doctoral and masters level students from Brown University's Department of Epidemiology who will attend quarterly SEOW meetings, solicit recommendations for new data analyses and graphic depictions, conduct and distribute results. In addition, the Community Research and Services Team (CRST) will work closely with RIPRC and the SEOW to develop coalitional capacity profiles derived from coalition member surveys and interviews with coalition paid coordinators and volunteer chairs. In this way, the SEOW will not only provide communities with substance abuse data but also with data on the health of the coalition "platforms" from which prevention programs, policies and practices are mounted.

SECTION B: PROPOSED APPROACH

B.1 Purpose, goals and objectives

The **purpose** of Rhode Island's Partnerships for Success program is to enhance the current prevention infrastructure by expanding the capacity to identify current and emergent prevention populations and concerns and to address those concerns with culturally appropriate evidence-based programs, practices, and policies. The purpose is consistent with SAMHSA's Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness. The Rhode Island Partnerships for Success initiative will facilitate a more comprehensive approach in Rhode Island to SAMHSA's 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; and goal 1.2: Prevent or reduce the consequences of underage drinking and adult problem drinking.

The **goal** of Rhode Island's Partnerships for Success program is to support twelve high-need Rhode Island communities in using evidence-based prevention programs, policies and practices to reduce underage drinking and marijuana use among youth age 12-17. To achieve this goal, the project has the following objectives, which parallel the steps of the Strategic Prevention Framework (SPF). The Objectives are based upon an October 1, 2013 start date.

Objective 1. Partnership formation*:* By November 1, 2013, each of the designated twelve high need communities will engage representative from a minimum of five local partners representing varied community sectors (e.g., schools, law enforcement, health services, government and community groups). These partners will agree to be central participants in and supportive of the planning, implementation and data collection for the local SPF PFS initiative.

Objective 2. Capacity building*:* By November 30, 2013, the Rhode Island Prevention Resource Center (RIPRC) will identify specific training and technical assistance needs of sub-recipient communities and will, using the expert resources of BHDDH, RIPRC and SEOW staff, provide training and technical assistance to all sub-recipient communities which will help them prepare their local strategic plan and outline the kind of ongoing guidance and support they will need with implementation.

Objective 3. Strategic Plan Development*:* By March 1, 2014, the designed twelve high need communities will submit a local strategic prevention plan for addressing their substance specific target of either underage drinking (Burrillville, Cranston, Providence and Westerly), marijuana use (Cumberland, Lincoln, Little Compton and Scituate) or both (Foster, Johnston, New Shoreham and Newport). The strategic plan will meet the requirements of a BHDDH issued SPF PFS funding announcement issued closely upon SPF PFS start up, including specification of local risk and protective factors related to the target substance and evidence-

based programs, policies and practices which will be used to address those local risk and protective factors.

Objective 4: Implementation: By April 15, 2014, all twelve high need communities will commence implementation of a comprehensive prevention approach targeted to the local priority substance(s). Implementation will include an array of evidence-based interventions to produce change in youth themselves (e.g., changes in knowledge, attitudes and behavior) as well as environmental strategies to change the community environment that influences youth behavior (e.g. community and organizational policies and practices).

B.2 Proposed Prevention Priorities:

One **proposed priority** for Rhode Island is to reduce underage drinking in youth ages 12-17. National, regional, and state data sources identify alcohol abuse and underage drinking as continuing state priorities. These continue to be problem areas but have shown downward trends nationally and within our state. Table 3 below provides a summary of underage drinking among students in grades 9-12 from 2001 and more recent years (2009, 2011) from the Youth Risk Behavior Surveillance System. Levels of youth drinking before age 13 and problem use (binge drinking) are consistent with other northeastern states and typically lower than the US overall.

TABLE 3
UNDERAGE ALCOHOL USE (ALCOHOL USE AMONG STUDENTS GRADES 9-12)

	USA	CT	MA	ME	NH	NJ	NY	PA	VT	RI
	Binge drinking (5+ drinks in one sitting) past month									
2001	**29.9%**	--	32.7%	31.5%	--	32.6%	--	--	29.0%	**30.7%**
2009	**24.2%**	24.2%	24.5%	--	24.0%	26.7%	23.8%	21.9%	23.1%	**18.7%**
2011	**21.9%**	22.3%	22.2%	16.2%	23.8%	23.7%	22.0%	--	20.9%	**18.3%**
	Initial use of alcohol before age 13									
2001	**29.1%**	--	27.9%	21.7%	--	32.5%	--	--	26.0%	**29.7%**
2009	**21.1%**	17.6%	17.2%	20.3%	14.8%	18.0%	21.0%	19.0%	18.2%	**15.8%**
2011	**20.5%**	15.6%	14.6%	15.8%	14.3%	14.4%	19.0%	--	14.8%	**15.6%**

While we have reason to believe that Rhode Island's ability to impact underage drinking may have resulted from the SPF-SIG effort in RI (Florin, et al., 2012) there are compelling reasons to continue to focus efforts in Rhode Island on a priority of underage drinking. One of these of course is the simple fact that prevention is never done once and for all, that new cohorts of youth continue to be exposed to personal and community risk factors for early use and, potentially, problem use of alcohol. Another, more specific reason for underage drinking as a prevention priority is that the targeted high need communities in this SPF PFS initiative experienced only a modest decline in underage drinking that was one-third the impressive reductions experienced in the remainder of the state. Finally, only three of the eight identified alcohol high need communities (Newport, Providence and Westerly) were involved in the prior SPF-SIG. We are

thus expanding our underage drinking efforts to additional, new communities, while still shoring up some of the previous SPF-SIG communities that warrant attention.

B.3 An additional data driven prevention priority for Rhode Island is to reduce marijuana use among youth ages 12-17. The recently released *State Estimates of Substance Use from the 2009-2010 National Surveys on Drug Use and Health* (Office of Applied Studies, NSDUH Series H-37, HHS Publication No. SMA 10-4472, Rockville, MD) reports that RI ranks in the top fifth of states for past month marijuana use, number one in past year marijuana use, and in the top fifth of states for first use of marijuana in the past two years (incidence). Survey results also find that RI had the highest rate of past year use of marijuana in the 18 – 25 year old group and along with Colorado and Vermont had the highest rate of incidence among 12 – 17 year olds. These data are consistent with YRBS survey data showing that past month prevalence among Rhode Island youth typically exceeding regional and national averages.

TABLE 4. UNDERAGE MARIJUANA USE (MARIJUANA USE AMONG STUDENTS GRADES 9-12)

	USA	CT	MA	ME	NH	NJ	NY	PA	VT	RI
	Using marijuana past month									
2001	**23.9%**	--	30.9%	27.2%	--	24.9%	--	--	30.3%	**33.2%**
2009	**20.8%**	21.8%	27.1%	20.5%	25.6%	20.3%	20.9%	19.3%	24.6%	**26.3%**
2011	**23.1%**	24.1%	27.9%	21.2%	28.4%	21.1%	20.5%	--	24.4%	**26.3%**
	Initial use of marijuana before age 13									
2001	**10.2%**	--	11.9%	12.0%	--	9.2%	--	--	12.2%	**12.8%**
2009	**7.5%**	5.8%	9.0%	9.8%	8.4%	4.1%	7.7%	5.3%	8.7%	**8.3%**
2011	**8.1%**	6.3%	6.9%	7.3%	7.7%	4.3%	7.6%	--	6.4%	**7.1%**

The Rhode Island SPF PFS will mount interventions in twelve high need communities to address both priorities of underage drinking and marijuana use among youth. In addition, Rhode Island intends to use the SPF PFS grant program as an opportunity to assess prescription drug use and misuse among youth ages 12 - 25, and resulting burden. Currently, there are only very limited data available specific to Rhode Island on prescription drug use and misuse among youth ages 12-25. Data from the Youth Risk Behavior Survey data indicate that 11% of Rhode Island public high school youth abuse prescription medications in their lifetime. We will use the SPF PFS as an opportunity to compile all available data and conduct new state and sub-state analyses to assess our needs and get a better understanding of the incidence and prevalence of prescription drug use and misuse in order to consider potential prevention strategies.

The additional priorities will not diminish from the success or impact on our first priority: continuing reduction of underage drinking. Department prevention staff analyses of funding streams available for implementation of preventive interventions suggest that there are sufficient resources to support the maintenance of previous gains and to contribute to further reductions in underage drinking, if combined with the resources available through this award. (This award will

provide support to the underage drinking advisory committee in the fourth federal quarter and serve as a vehicle to transition the policy development activities of the advisory committee to the SPF-PFS. This will maintain important and necessary policy development functions in support of local underage drinking prevention initiatives.)

B.4 Proposed Approach and Level of Effort

Addressing the SPF PFS priorities through communities of high need: Rhode Island will implement the following approach with the twelve high need communities which have been identified. We describe the generic approach according to the SPF process that is linked to each of our objectives described in Section B.1:

- *Partnership formation*: Upon receipt of a SPF PFS grant, BHDDH will develop an annoucement of avaiable funding for the spefic tweleve communities to address specific substances, namely underage drinking (Burrillville, Cranston, Providence and Westerly), marijuana use (Cumberland, Lincoln, Little Compton and Scituate) or both (Foster, Johnston, New Shoreham and Newport). Strong community partnerships are necessary to effectively address the priority substances in these high need communities. BHDDH will require that each local partnership identify a minimum of five local partners drawn from a variety of community sectors such as schools, law enforcement, health care providers, youth groups, faith-based organizations, community groups who have agreed to work together on planning, implementation and data collection.
- *Capacity building*: RIPRC will identify intial training and technical assistance (TTA) needs in each of the twelve sub-recipient communities. Capacity building needs will be prioritized so that common needs will be addressed across communities, while more specialized needs will be tailored for individual communities. The TTA process will be ongoing and iterative, with new needs emerging beyond those initially identified. This we expect to occur throughout the duration of the SPF PFS.
- *Strategic Plan Development*: BHDDH and RIPRC will use the SPF process with each of the twelve high need communities to assess their local prevention needs in terms of their targeted substance(s). This will include using local data to refine the problem assessment and to identify risk factors with the youth population (e.g., lack of perception of harm) and contributing conditions within the community environment (e.g., community norms favoring use or easy access). After local risk and protective factors are identified, evidence-based programs, policies and practices that address such factors will be selected. BHDDH and RIPRC will provide resources to local communities containing potential intervention strategies. There are a wide variety of resources avaiable to address underage drinking, for example, those contained in SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP). However, the literature on evidence-based interventions which reduce prevalence of marijuana use is more limited, especially with regard to environmental interventions. We will rely on a comprehensive literature review of strategies and interventions for reducing marijuana use produced in 2012 by the CAPT Northeast Resource Team and any new emprical literature that emerges concerning reduction of marijuana use among youth.
- *Implementation*: BHDDH and RIPRC will support all of the high need sub-recipient communities as they work to implement their chosen strategies. BHDDH and the RIPRC will provide systematic and sustained support and guidance to sub-recipient communities through the life of the project, as described in the paragraphs below.

Adequate support and guidance to subrecipient communities: The RIPRC has a multifaceted training and technical assistance (TTA) approach to support community-based environmental prevention interventions, including support for the implementation of evidence-based prevention programs and practices and the development of a well-trained substance abuse prevention workforce. RIPRC TTA is organized into five modalities: 1) Individualized/Organizational-specific TTA; 2) Learning Collaboratives (LC); 3) Content-specific Training; 4) a website, www.ricprc.org, for sharing resources and promoting training sessions; and 5) Collaboration with other TTA Providers. Using these TTA modalities, RIPRC will provide multiple, tailored levels of information (basic to advanced) to respond to the range of capacities of BHDDH and its subrecipient communities. Based on the premise that technology transfer occurs through an intentional process of performance improvement[1], the LC use an action-learning methodology to facilitate the development of learning teams. TTA will be provided in-person to individuals and groups, and through the website. The website, www.riprc.org serves as a clearinghouse of substance abuse prevention information with links to programs, providers and resources. The RIPRC aims to establish a culturally competent TTA program designed to be appropriate and accessible, incorporate adult learning principles, and address the diverse learning styles and backgrounds of participants. Every effort is made to maximize peer-learning opportunities through all TTA modalities.

BHDDH understands the challenges and barriers to implementing evidence-based approaches in community program settings and is capable and committed to proactively building programs' capacity and the infrastructures of the high need subrecipient communities. Building upon the needs already recognized in **Section A** above, the high need subrecipient communities are disproportionately in need of enhanced and tailored capacity building and infrastructure development based on the data provided in this proposal. In addition to building capacity in the state, the subrecipient communities also include expanded target populations and issues identified in **Section B**, including, but not limited to: veterans and military families, physical and emotional challenges/disabilities, gender, age, economic status, race, ethnicity, sexual/gender identity, and/or faith/religion

Subrecipents will be supported to implement and promote continual quality improvement planning, which includes monitoring and evaluation for program improvement and sustainability. The RIPRC, SEOW, EBP Workgroup, and CRST will be able to provide support and guidance for subrecipient communities at all of the SPF steps.

***Identifying and selecting communities of high need*:** Our approach and methodology to identify and select communities of high need was to use municipal level data which was collected for all 39 cities and towns of Rhode Island. In order to prioritize the municipalities in Rhode Island with the greatest need for intervention for underage drinking for youth aged 12 to 17 years old and marijuana use for youth aged 12 to 17 years old, we considered several metrics.

First, we relied heavily on student self-reported data collected from the SALT Survey in Rhode Island, known nationally as the High Performance Learning Communities Assessment. All students in grades 4-12 in Rhode Island completed this survey, with the exception of students who have been excused by their parents and students with Individual Education Plans who are

[1] Addiction Technology Transfer Center. (2004). *The change book: A blueprint for technology transfer.* Kansas City, MO: Author. Available at: www.nattc.org/thechangebook.

unable to take the survey. Response rates for the variables we considered ranged from 77% to 100%. The SALT survey was discontinued after the 2007-2008 school year, and a new school-based survey (SurveyWorks!)was piloted in 2009-2010 and fully implemented in 2010-2011. Based on differences in wording and response categories, only some indicators could be used across these two surveys

1) Underage drinking

We analyzed data collected from the earliest administration (1999-2000), most recent administration (2010-2011) as well as interim school years (2005-2008) for high school students and for the 2011-2012 school year for middle school students. When considering the burden of underage drinking among youth across municipalities, for high school students we opted to NOT use reports of "any" drinking (which could be inflated by rare, light consumption patterns) and instead prioritized moderate levels of moderate alcohol use (6 or more times during the past 30 days). This information was available for all four survey time points. Average moderate alcohol use among high school students across the four time points ranged from 12.7% to 25.0%. The 5 municipalities with average moderate alcohol use greater than 22% were included as high priority communities (see Table 5 below). We chose to consider moderate use over the past 12 years to identify communities with consistently high levels of burden.

We then considered the percent change for moderate alcohol use among high school students from the 1999-2000 school year to the most recent year available (typically the 2010-2011 school year). The intent here was to identify additional communities that may have lower average levels of consumption but where levels were increasing over time (suggesting regions of future potential concern). The proportion of high school students reporting moderate alcohol use declined in all municipalities, except for one municipality (New Shoreham). The percent change ranged from a reduction of 71% to a reduction of 21%, with New Shoreham rates increasing 150%. The four municipalities with least reductions in moderate alcohol use (>-30%) or an increase were included as prioritized communities.

Finally, to ensure the consideration of middle school students in prioritizing communities, we included a measure of current alcohol use, defined as students who answered yes that they "have drunk alcohol between one and 30 days in the past month." It was critical to treat this middle school indicator separately from the high school indicators because reports of current alcohol use among middle school students were negatively correlated with moderate alcohol use among high school students (r=-0.40). In Rhode Island, communities that report high levels of middle school use differ from those that report high levels of high school student use. This may be due to a number of factors, including over-reporting by younger students, under-reporting by older students, that those who drink in high school may be absent, and other possible explanations. Middle school current alcohol use in 2011-2012 school year ranged from 3% to 13%. The 7 municipalities (18%) reporting that greater than 10% of middle school students had used alcohol in the past 30 days were included as prioritized communities.

2) Underage Marijuana Use

Similar approaches were used to prioritize communities with regard to marijuana use among youth age 12-17 years. For middle school students, we were able to use recent (2011-2012) reports of ever using marijuana. For high school students, the drug use questions changed between 2008 and recent administrations, and currently includes only questions about being under the influence of drugs at school, being sold or offered drugs at school or on the way to

school. Though these measures were highly intercorrelated (0.7 – 0.8), our analyses suggest that these are not good surrogate measures for general levels of use, because students who regularly use marijuana outside of the school setting would be overlooked. Student reports on these questions showed low correlation with trend data for general levels of illicit drug use over the past 10 years and with middle school reports of any use. Thus, we limited analyses to the earlier survey data, from 1999-2000, 2005-2006, and 2007-2008 and for high school students considered: a) average levels of use across this 10 year period and; b) percent change in use from 1999-2000 to 2007-2008. As with alcohol, we considered but did not use reports of "any" illicit drug use (which could be elevated due to light limited use) and considered moderate illicit drug use (3 or more times in the past 30 days). The average across the three school years ranged from 11.3% to 30.0%. The 5 municipalities with greater than 27% average moderate marijuana use among high school students were included as prioritized communities (see Table 1 below).

We then considered the percent change of moderate illicit drug use among high school students from 1999-2000 to 2007-2008. The proportion of high school students reporting drug use declined on average, however, but ranged from a reduction of 41.7% to an increase of 52.6%. The 4 municipalities with increases in moderate levels of drug use (>10%) were included as prioritized communities.

Again, to ensure the consideration of middle school students in prioritizing communities, we considered a measure of ever using marijuana, defined as students who answered yes that they "have tried marijuana (pot, grass, hash)." The percent of middle school students reporting ever using marijuana in the 2011-2012 school year ranged from 0% to 9%. All municipalities reporting greater than 6% of middle school students having ever used marijuana were included as prioritized communities.

This process was designed to identify and use the best available data in a fashion consistent with our objectives (to select communities of high need). The results, shown in Table 5 identified 17 of 39 municipalities in Rhode Island. As a result of ongoing local prevention initiatives, prevention funds are already in place for 5 of these. The remaining 12 (shown in bold) are the communities that we propose to target for this work. The final list and selection strategy may change slightly as we review the logic and methods described above with our advisory team.

Table 5

	Underage Alcohol Use Indicators			**Illicit Drug Use Indicators**		
Municipalities	*Average Moderate Alcohol Use (1999-2011) Among High School Students > 22%*	*% Change in Moderate Alcohol Use among High School Students from 1999-2011 > -30%*	*% Current Alcohol Use among Middle School Students 2011-2012 > 10%*	*Average Moderate Illicit Drug Use (1999-2008) among High School Students > 27%*	*% Change in Moderate Illicit Drug Use among High School Students from 1999-2008 > +10%*	*% Ever use Marijuana among Middle School Students 2011-2012 > 6%*
Burrillville			X			
Central Falls			X			
Cranston		X				

Cumberland					X	
Foster	X			X		
Glocester	X			X		
Johnston		X	X		X	X
Lincoln					X	
Little Compton				X		
New Shoreham	X	X		X		
Newport	X		X			X
Pawtucket			X			X
Providence		X	X			
Scituate					X	X
Tiverton				X		X
Westerly	X					
Woonsocket			X			X

Considering the needs of tribes and tribal entities: The Narragansett Indian Tribe is Rhode Island's only federally recognized tribe, led by Chief Sachem Matthew Thomas. The Tribe is currently involved with a community coalition in the Southwestern part of Rhode Island. Two members of the Tribe serve on the coalition, and the coalition has hosted cultural training by the Narragansett Tribe. In addition, Tribal members recently participated in a focus group for a Positive Community Norms Model as part of BHDDH's Reducing Marijuana and other Illicit Drugs initiative. BHDDH will reach out to Chief Thomas and the tribe directly as part of this SPF PFS initiative to get a better understanding of the Tribal needs.

Are changes in sub-recipient communities expected to lead to state-wide reductions?: As shown in Table 3 (above) RI has evidenced dramatic reductions in youth problem alcohol use between 2001 and 2011. These reductions have typically surpassed national and regional trends and, we propose, may well be the result of the prior SPF-SIG efforts which targeted youth drinking behavior. In contrast, Table 4 does not indicate comparable reductions for youth marijuana use. We provide this as evidence of the huge potential for the SPF PFS model to result in substantial statewide reductions in targeted substance use behaviors.

***Documenting prevalence rates and community needs*:** Multiple federal and state agencies continue to monitor and collect indicators of behavioral health across the state of Rhode Island and its communities. As reflected in past SEOW activities, these cover both adult and underage substance use problems as well as their social, behavioral, and health consequences. The SEOW will continue to collect, analyze, and report on the priority substance consumption patters specified as part of this proposal (underage drinking and marijuana use among 12-17 year olds), and will initiate collecting and reporting on state and community level indicators of prescription drug use and misuse to assist in future prevention planning.

The RI SEOW team will identify and retrieve state and community-level indicators (when and if available) from the on-going national surveys such as the National Survey on Drug Use & Health (NSDUH), Behavior Risk Factor Surveillance System (BRFSS), as well as maintaining and expanding its established collaboration with various state agencies to ensure data collection and sharing at the state and sub-state level, focusing specifically on the targeted communities and targeted indicators of youth alcohol and marijuana use. For example, we will work with the Rhode Island Department of Education to continue school-based surveys of all students in grades 4-12 with a new school-based survey (SurveyWorks!) that was piloted in 2009-2010 and fully implemented in 2010-2011. We will draw on the expertise of members of the SEOW from multiple RI agencies to continue to access, integrate and share all available community level data related to the aims of this project. Bi-annually or annually we will produce summaries of levels of substance use, risk and protective factors for all 39 RI municipalities, both those targeted for the current work and all others. These will include tabular and graphic depictions of state and community values to aid in their use and interpretability.

In addition, BHDDH has contracted with SmartTrack to conduct a Rhode Island Student Survey that will be a requirement of funding for all 12 sub-recipient communities in this grant. The RI Student Survey will be used to track 30-day prevalence of alcohol, marijuana and prescription-drug misuse and abuse among 12-17 year olds at the community level. The RI Student Survey is a 54-item population survey (i.e., it includes all students in school on the day of administration) that will be administered yearly as a condition of funding in all public middle and high schools in the 12 subrecipient communities. The RI Student Survey contains items providing 30-day prevalence rates comparable to those provided at the state level by NSDUH and YRBS. In addition, the RI Student Survey asks about 30-day use of specific categories of prescription drugs (e.g., opioids / pain relievers; tranquilizers/sedatives and stimulants), allowing for a more refined assessment of trends in the non-medical use of particular types of prescription drugs.

***Monitoring and using data to track community progress/ensuring data submission*:** Please see Section D (Performance Assessment and Data) below for a full response to this question.

Timeline: The 5 year timeline below shows major activities at both state and subrecipient levels.

	2013-2014				2014-2015				2015-2016				2016-2017				2017-2018			
	Quarters				Quarters				Quarters				Quarters				Quarters			
Major Activities	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep
State Level																				
• BHDDH convenes State Evidence-based workgroup, develops guidance document for subrecipients	**X**	**X**																		
• SEOW produces community profiles for subrecipients, intially and then yearly	**X**				**X**				**X**				**X**				**X**			
• RIPC provides TTA to subrecipients for development of local strategic plan	**X**	**X**																		
• RIPC provides implementation TTA to subrecipients for duration of SPF PFS			**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
• CRST gathers state level data and reports on performance assessment to CSAP		**X**		**X**		**X**		**X**		**X**		**X**		**X**		**X**		**X**		**X**
• BHDDH reviews / approves subrecipient community strategic plans /issues funds			**X**																	
Community Level																				
• Subrecipient communities form partnerships		**X**																		
• Subrecipients work with RIPC to build partnership capacity in general, and more specifically, to identify risk and protective factors, select an array of straegies and		**X**	**X**																	

develop strategic plan																				
• Subrecipients begin implementation of strategies after BHDDH approval (by June 1, 2014) and continue to implement for the duration of SPF PFS, receiving TTA from RIPRC			**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
• Subrecipients report to BHDDH quaterly online			**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
• CRST conducts coalition survey, leader interviews and monitors implemenation fidelity			**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
• SmartTrack conducts school survey (outcomes)		**X**				**X**				**X**				**X**				**X**		

***Assisting funded communities with Advisory Council, SEOW and Evidence-based workgroups*:** The Governor's Council on Behavioral Health acts as the state behavioral health planning council to BHDDH and the Governor on any funds made available to the BHDDH by the federal government for substance abuse and/or mental health treatment and prevention purposes. This Council is currently active and is composed of 26 public (voting) members who include representation of providers and consumers of mental health and substance abuse treatment and prevention services. The Council would assist funded communities in the use of interdisciplinary approaches to preventing substance abuse prevention with a focus on integration of support systems.

The SEOW will continue to institutionalize data-driven decision making for state and community level prevention planning with an expanded focus that integrates behavioral health indicators such as preventing mental illness and promoting positive mental health as it relates to substance abuse. The SEOW will produce and disseminate statistical profiles of demographics, risks, assets and resources at municipal level and provide technical assistance to aid funded communities in translating the municipal profiles into a logic model.

BHDDH is receiving Technical Assistance from the Center for the Application of Prevention Technologies in the development of an Evidence Based Program Workgroup. We are in the early stages of determining the Workgroup goals, members and resources. The purpose of this Workgroup will help to increase the use of evidence based practices for our funded communities.

***Addressing demographics, diversity and culture*:** When considering the role of diversity in Rhode Island's SPF PFS initiative, we are struck by, and want to remain very mindful of at least three different issues: (i) the different demographics and racial /ethnic composition of our subrecipient communities; (ii) the role of what have been called the "social determinants" of health which include economic factors and (iii) the absolute necessity of addressing "unheard voices" such as LGBQ youth.

Concerning issues (i) and (ii), as shown in Section A, our alcohol targeted communities had high proportions of minority residents, approximately twice the values of the state as a whole, and more poverty than the communities targeted for marijuana. These demographics are important on a broad level because of the changing face of America and the changing face of Rhode Island (and other regions of the U.S.), where in a minimal growth state Hispanic and non-Hispanic black populations increased significantly. But on a more specific level, this requires that our planning and implementation of prevention efforts engage racial, ethnic and linguistic minority communities. These demographics also demand that we review cultural responsiveness from our workforce and examine any curricula employed for its cultural responsiveness.

Concerning issue (iii), the 2011 RI Youth Risk Behavior Survey (YRBS) findings document the increased need for underage drinking and marijuana use prevention for lesbian, gay, bi-sexual and questioning (LGBQ) populations. Underage drinking among lesbian, gay and bisexual students declined from 2007 (65% to 49%), but remained higher for this group in 2011 (49% vs. 33%) than amongst other students. Marijuana use is higher among non-heterosexual students (39% vs. 25%), and the abuse of prescription and 'over-the-counter' drugs is twice as high (35% vs. 15%). Emotional disability is more prevalent among lesbian, gay and bisexual high school students (31% vs. 13%), and acute depression is 2½ times more common (55% vs. 22%). LGBQ students are also four times more likely to attempt suicide (29% vs. 7%). Factors such as verbal and physical harassment, negative experiences related to "coming out" (including level of family

acceptance), substance use, and isolation all contribute to higher rates of suicidal attempts and completions among gay men and LGBQ youth than other populations. Limited youth transgender data has been collected in Rhode Island. One of the most frequent concerns is a lack of understanding and support from non-LGBTQ individuals. BHDDH will address sexual and gender identity in the SPF PFS prevention initiative on state and community level. First, the RIPRC will provide subject matter expertise based on existing organizational experience working on health-related projects, including, substance abuse prevention and treatment, in lesbian, gay, bisexual, transgender (LGBT) other men who have sex with men (MSM) communities to all subrecipients in an effort to increase understanding and support across the prevention provider system. Secondly, subrecipients with existing experience with this population and whose prevention activities are geared toward reducing LGBT underage drinking and marijuana use will receive additional resources to reach and provide services to this disproportionately at risk population.

Finally, adherence the National Standards for Culturally and Linguistic Appropriate Services (CLAS) will be monitored by BHDDH during site visits to ensure all funded communities have documentation on how they have involved diverse segments of their communities and demonstrate how issues of diversity are being addressed by their programs and in their strategies.

SECTION C: STAFF, MANAGEMENT, AND RELEVANT EXPERIENCE

C.1 Capability and Experience.

The RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals is the single state authority for prevention and treatment and administers all significant substance abuse prevention for alcohol and other drugs. In 2005 the Department consolidated the separate behavioral health planning and prevention units into a single unit with responsibility for developing the CMHS and SAPT Block Grant applications/plans and reports, coordinating SAMHSA discretionary grant applications, and managing all substance abuse prevention and underage access to tobacco activities. This broad, but focused scope of work enabled the transfer of Rhode Island's SPF SIG award from the Executive Office of Health and Human Services to the Department. The Department used this opportunity to initiate transfer of the SPF conceptions and process to our state and SAPTBG funded prevention providers. Also, findings from the SPF SIG formed the basis of the draft Strategic Plan for Prevention, 2010 – 2015. In FFY 2011 the Department collaborated with the state Department of Elementary and Secondary Education on development and implementation of US Department of Education Building State Capacity for Preventing Youth Substance Use and Violence grant. The collaboration resulted in a RI prevention program inventory; and the advisory committee for the grant reviewed and had significant input into the draft Strategic Plan.

Based on the findings of the SPF SIG and of the SEOW, the Department developed a SAPTBG funded initiative to reduce marijuana and other drug use. This initiative, which serves to pilot various approaches to reducing marijuana use among high school students, is being implemented in high schools in 9 communities—some of which have been identified as high priority communities for implementation of the SPF PFS. The initiative includes administration of the RI Student Survey (RISS), a newly developed incidence and prevalence survey based on the Missouri Student Survey and cross-walked with the Communities That Care survey.

The state has contractual relationships with each of the state's 35 community coalitions that represent all of RI's 39 municipalities. The state prevention coordinator has worked with the

coalitions to assist them with incorporating the SPF model into their planning efforts. The Department also contracts with the three providers of Student Assistance services based on the Project Success model; the three providers cover 44 middle and senior high schools.

In 2011 the Department was awarded a contract from the US Food and Drug Administration to implement the FDA Tobacco Inspection Program; this is in addition to the Department's lead role in the state to reduce youth access to tobacco, including conducting the annual Synar survey.

The proposed Project Director and Principal Investigator have extensive experience with planning, administrating, and supervising substance abuse prevention activities in all of RI's communities and with all facets of its population.

C.2 Staffing and Demonstrated Experience

Principal Investigator – Charles E. Williams – 10% effort (in-kind): Mr. Williams, an Associate Director, serves as the Chief of Prevention and Planning, and Data and Research in Behavioral Health. Mr. Williams will provide overall operational supervision. Mr. Williams has extensive and broad experience in the prevention and behavioral health fields (see resume). He has served as the state prevention coordinator (NPN) for Connecticut, Missouri, and Rhode Island and in the private sector has directed large federally funded prevention technical assistance and support contracts.

Project Director – Elizabeth Kretchman - 20% effort (in-kind): Ms. Kretchman is the coordinator of behavioral health prevention services for the department, and the state's National Prevention Network representative. Ms. Kretchman is the lead for the development of the primary prevention set-aside plan for the SAPTBG and the mental health promotion component of the CMHSBG. She is the project officer for community coalitions funded through the RI Substance Abuse Prevention Act, student assistance providers, and the marijuana initiative. Ms. Kretchman represents the Department on the planning committee for the Youth Risk Surveillance Survey administered by the Department of Health and the Suicide Prevention Committee, also administered by Health. She is the project director for the SEOW contract. Ms. Kretchman has 20 years of experience in the substance abuse treatment and recovery field in addition to her experience and work in the prevention field. She will directly supervise the Project Manager and provide overall direction and management for the project. Ms. Kretchman will be directly supervised by Mr. Williams.

Project Manager- 100% effort (to be hired): The Project Manager, to be hired, will function as the day-to-day manager of the project. The Project Manager will have demonstrated grant management experience that will include experience working with urban and suburban communities implementing evidence-based primary prevention programs, policies, and strategies. (This position will be posted in time to allow it to be filled in the first quarter of the award.) Elizabeth Kretchman, see above, will manage the project until a Project Manager is approved.

Project Assistant- 100% (to be hired): The Project Assistant, to be hired, will manage all administrative aspects of the grant, including monitoring deliverables and required data entries, summarizing meeting outcomes, scheduling, and other, non-supervisory administrative support functions. The Project Assistant will have demonstrated, modern computer skills and experience supporting complicated projects. The Project Assistant will be supervised by the Project Manager.

Project Evaluator- Paul Florin, Ph.D., 25% effort: : Dr. Florin directs the Community Research and Services Team, University of Rhode Island, which will conduct the statewide evaluation of the project. He will be responsible for the management and implementation of project evaluation activities at the state and community levels. The principal evaluator will meet monthly with the Project Director and Project Manager, as well as the State Epidemiological Task Group. Dr. Florin's research interests focus on the relationships between community conditions and the health of community populations and the design of training and technical assistance systems for such initiatives. Dr. Florin has also been a consultant around the design of community based prevention programs and training and technical assistance systems to national and international organizations.

Lead Epidemiologist & Co-Chair State Epidemiology and Outcomes Workgroup- Stephen L. Buka, Sc.D., 30% effort: Dr. Buka will lead the State Epidemiological Workgroup that will conduct data systems, surveillance and project monitoring support and continue to serve as co-chair for the SEOW, a role he has held for the past 7 years. The Lead Epidemiologist will meet monthly with the Project Director and the Evaluator, and will represent the State Epidemiological Workgroup in Governor's Council on Behavioral Health meetings. Dr. Buka is Professor and Chair of the Department of Epidemiology at Brown University

Data Analyst / Associate Lead Epidemiologist- 39% effort: Dr. Jasmina Burdzovic Andreas is an Assistant Professor (Research) appointment in the Department of Epidemiology at Brown University and current recipient of a K01 award from NIDA. She received a PhD in Developmental and Social Psychology from Brandeis University in 2003 and Masters Degree in Epidemiology from Brown University in 2012. She will assist Dr. Buka with all epidemiologic tasks and analyses, as she has done for the SEOW for the past four years.

C.3 Discuss how key personnel have demonstrated experience

The proposed key personnel have many years of experience and expertise in one or more of the following areas: epidemiology, program evaluation, program planning, and program implementation and management. Each of the named key personnel also has broad experience working with diverse populations, including the cultures and languages of the populations in the communities that may be funded through this project. For example, prior to her tenure with the State of Rhode Island, Ms. Kretchman was the director of RICARES, RI's nonprofit, community based recovery organization; she currently works closely with each of the state's 35 community coalitions providing consultation and oversight. Dr. Florin has over 20 years experience leading state and local evaluations of RI community coalitions and other prevention providers; he also led the state level evaluation of RI's SPF SIG. Dr. Buka is a nationally recognized epidemiologist with specializations in children's health and well being in addition to substance use; he was the co-chair of the SEOW funded through the SPF SIG. Dr. Burdzovic has clinical research training in the area of families and addiction and holds an appointment in the Brown University Department of Epidemology; she has been involved with the SEOW for the past four years. The project team currently in place has deep experience with local populations and with the design of approaches that are congruent with the cultural diversity found in RI.

The Project Manager, to be hired, will be expected to have demonstrated experience not only working with community coalitions, but also in the management of prevention-focused programming.

SECTION D: **PERFORMANCE ASSESSMENT AND DATA**

The Community Research and Services Team (CRST) of the University of Rhode Island will conduct the evaluation

Required Performance Measures (Process) The SPF PFS RFA lists five required GPRA process measures at the Grantee (State) level and four required process measures at the Community (subrecipient) level. At the State level, process measures are required that cover the number of State sponsored training and technical activities provided per funded community (including numbers reached), increases in evidence-based programs, policies and practices adopted by the sub recipient communities, leveraging of State resources and data reporting by subrecipients into the state data system. At the Community (subrecipient) level, the required process measures include local adoption/adaptation of evidence-based program, policies and practices, cross-sector collaboration, leveraging of local resources and numbers of individuals served by IOM prevention categories. Rhode Island is ready and able to report data on each of the required process measures twice a year into SAMSHA's online reporting system:

- *Technical Assistance and Training (State-Level)*. The previously described RIPRC will be responsible for providing TTA to all subrecipients of the SPF PFS initiative in RI. The two required state-level TTA process measures (1) number of TTA activities per funded community provided by the state and (2) reach of TTA (numbers served) are contained within a TTA database maintained by RIPRC. RIPRC tracks all services provided by numbers and positions of individuals served (e.g., an individual coordinator or an entire coalition), amount and type of services, topic area(s) covered and follow-up action steps taken. Data can be retrieved at the individual, program, or community coalition level. RIPRC reports TTA data to BHDDH on a *quarterly* basis. The CRST will retrieve this data on the number of TTA services delivered to SPF PFS subrecipients and the number of individuals served.
- *Evidence-Based Programs, Policies and Practices (State-Level)*: BHDDH has scheduled technical assistance from the Northeast Center for the Application of Prevention Technology (CAPT) to assist in the establishment of an evidence-based workgroup/panel. The workgroup will be tasked with identifying effective evidence-based programs, policies and practices and developing guidelines to assist communities in deciding on the most compatibility choices for their local context. Currently, BHDDH funded communities are required to report data *quarterly* into an online reporting system that includes a field that asks communities to report on the number of evidence-based programs, policies, and practices implemented each quarter. The CRST will retrieve this information for SPF PFS subrecipient communities, utilizing "evidence-based" as defined by the EBP workgroup, and track this information from baseline across subsequent reporting periods to determine the percentage of subrecipient communities that have increased EBPs.
- *Leveraging of resources (State-Level)*. Rhode Island's State-Level Comprehensive Strategic Plan, conducted as part of SPF-SIG, assessed statewide funding streams related to prevention delivered through other state agencies, and has been working to align such resources on the state level. A similar process of leveraging and alignment of resources occurs at the subrecipient level, and the percentage of subrecipient communities that report an increase in prevention activities supported by leveraging of resources will be tracked within the SPF PFS. Each subrecipient will be asked to report in the online reporting system at least annually on (1) the total cost of all prevention initiatives they sponsor in their communities; (2) the proportion of the cost of such prevention initiatives that are paid for directly by SPF PFS

funds; (3) the amount of funds leveraged for each SPF PFS component from external sources (e.g., school committee paying for a curriculum) and (4) the dollar value of other leveraged resources or "in-kind" resources (e.g., dollar value of donated advertising space from a local newspaper for a social marketing campaign).

- *Data reporting system (State-Level):* All BHDDH funded programs are required to report quarterly process data in an online reporting system. Demographics and "dose strength" (e.g., number of sessions received) data for all individuals enrolled in universal and selected prevention curriculum are collected. In addition, a semi-structured qualitative reporting system tracks each significant action taken in the past quarter toward implementing environmental prevention strategies, as well as the consequences of such actions (e.g., meeting with school administrators about a new policy; steps taken toward launching a social marking campaign in the community). This quarterly reporting system will be required of SPF PFS subrecipients as a condition of funding, and BHDDH thus expects that all SPF PFS subrecipients will comply. BHDDH will identify missing data and monitor data quality and obtain submission and/or corrections as needed.
- *Cross-sector collaboration (local level)*: An annual semi-structured "leader interview" will be developed as part of the SPF PFS evaluation plan (see details below). The leader interview will be administered to community coalition (paid) coordinators and volunteer chairs of community coalitions. This survey will contain items designed to monitor multiple aspects of coalition functioning. A specific set of questions will query respondents as to the number and type of individuals/organizations participating in the community coalition, the sectors they represent (e.g., schools, faith community, parents, business), as well as specific collaborators or partners helping to implement each prevention strategy. Changes in sector representation and partnerships will be tracked over time.
- *Number of people reached by IOM categories (local level)*: As mentioned above, subrecipients will be required to submit *quarterly* online reports that provide demographics (e.g. age, gender, race, ethnicity) and dose strength data for all universal and selected curriculums. Estimates of the number of people "reached" by IOM universal indirect approaches such as environmental strategies is more difficult, but this can be estimated in various ways. For example for certain environmental strategies (e.g., the school population for a "social norms" intervention) the estimate can be the numbers and demographics for the entire school population. For a social marketing campaign in local news and other media, potential reach can be estimated through "audit bureau of circulation" figures for a local newspapers or actual "penetration" by a question in the RI School Survey that asking a youth to report whether they have read, seen or heard about a prevention campaign in the past year.
- *Evidenced-based Programs, Policies and Practices (local level)*: The number of evidence-based programs, policies and practices implemented by SPF PFS subrecipients will be assessed through the aforementioned BHDDH quarterly online reporting system that will be required. Definitions of EBPs will be those designed by the state level EBP workgroup, but the state anticipates using an adaptation of standard questions used in the SPF-SIG Community-Level Instrument (CLI) that asked if a strategy is evidence-based and the criteria used by the subrecipient to make the determination (e.g., appears in one of the several federal registries such as NREPP, Blueprints; supported by peer-reviewed journal publication, etc.). Tracking will be numbers of new EBPs introduced and maintained over time.
- *Leveraging of Resources (local level)*: As described above in the section *Leveraging of resources (State-Level)* subrecipient will be asked to report in the online reporting system at

least annually on (1) the total cost of all prevention initiatives; (2) the proportion of the cost paid for directly by SPF PFS funds; (3) funds leveraged for each component from external sources and (4) the dollar value of other leveraged resources or "in-kind" resources (e.g., dollar value of donated advertising space from a local newspaper for a social marketing campaign).

Required Performance Measures (Outcomes). The Rhode Island SPF PFS will address three outcomes among youth ages 12-17 in high need communities in the State: 30-day prevalence of alcohol use, prescriptions drug misuse and abuse and marijuana use. Per the RFA, the State has identified National Outcome Measures to assess the success of the initiative at the State and Community levels:

- *NOMS Data (State-Level).* Per the RFA, Rhode Island will use the National Survey on Drug Use and Health (NSDUH) state-level estimates to track 30-day prevalence of alcohol, marijuana and prescription-drug[2] misuse and abuse among 12-17 year olds. NSDUH data is gathered through a household interview methodology conducted yearly. Data gathered in 2011, 2012 and 2013[3] will be used as multiple-baseline years and compared with 30-day prevalence rates that emerge from NSDUH data collected in the years *after* the commencement of the SPF-PFS[4].

  In addition to the NSDUH data, the Youth Risk Behavior Survey (YRBS) will be used to provide another source of state level estimates of 30-day prevalence of alcohol, marijuana and prescription drug misuse and abuse. The YRBS is a representative survey of middle and high school students administered every two years. Data from 2011 and 2013 will be used as multiple-baseline years and will be compared with YRBS data that will be gathered in 2015 and 2017, *after* the commencement of the SPF PFS.
- *NOMS Data (Community-Level).* Rhode Island will use the RI Student Survey to track 30-day prevalence of alcohol, marijuana and prescription-drug misuse and abuse among 12-17 year olds at the community level. The RI Student Survey is a 54 item population survey (i.e., it includes all students in school on the day of administration) that will be administered yearly as a condition of funding in all public middle and high schools in the 17 subrecipient communities. The RI Student Survey contains items providing 30-day prevalence rates comparable to those provided at the state level by NSDUH and YRBS. In addition, the RI Student Survey asks about 30-day use of specific categories of prescription drugs (e.g., opioids/pain relievers; tranquilizers/sedatives and stimulants, allowing a more refined assessment of trends in the non-medical use of particular types of prescription drugs.

Additional Performance Measures. The RI Student Survey, in addition to the required NOMS, also contains items to measure intermediate outcomes (e.g., risk and protective factors) that may change as a result of the prevention interventions undertaken by subrecipient communities, thereby bringing about eventual changes in 30-day prevalence rates among youth. These items were drawn from well known youth surveys (e.g., Communities that Care survey) and are asked separately for alcohol, marijuana and, where appropriate, prescription drug misuse and abuse. The items include perceived risk / harm of use, perceived peer approval of use, parental disapproval, perceived ease of access, source of access, perceived adult/community norms for

[2] NSDUH inquires about different types of prescription drugs (e.g., stimulants, opioids) but combines them in reports.
[3] NSDUH state level estimate are crated by combining two years, for example 2009-2010 is compared to 2010-2011.
[4] NSDUH state level estimates are released 18 months *after* data collection.

use, perceived extent of use among students in school, probability of use if offered, perceived probably of enforcement by police and perceived family clarity of rules around drug use.

Using Data for Project Management and Continuous Quality Improvement. BHDDH has a solid track record of utilizing evaluation data to improve the management of specific projects, build capacity in community coalitions and guide ongoing improvements to the entire State prevention system. For example, BHDDH based its decision to utilize SAPTBG funds to establish the RIPRC on evaluation data that documented the relationship in Rhode Island between TA utilization and the ability to produce policy change on the community level (Florin et al, 2012). This attention to continuous quality improvement will continue in the SPF PFS. Implementation (e.g., process) evaluation measures will identify barriers and challenges and make timely changes to project management. Some of these implementation evaluation measures are very simple. For example, actions taken and actions to be taken at state level meetings will be recorded along with the person(s) responsible. This task recording will be reviewed at the beginning of each meeting to ensure task completion. At the conclusion of major state level and community coalition meetings, members will anonymously fill out a "meeting evaluation form". Members anonymously rate their agreement or disagreement with a number of statements about the meeting process and meeting output such as "Everyone had a chance to participate" or "We got a lot accomplished". The evaluator presents the range of scores and averages at the beginning of the next coalition meeting, so that "corrective action" can be taken by the those responsible for meeting management such as a coalition chair (e.g., making sure everyone is heard) or by members themselves (e.g., limit off-topic discussions).

Other implementation evaluation measures will be more detailed. For example, during the first funding year for community coalitions (and also in years 3 and 5) we will conduct a survey of coalition members using survey monkey. This survey anonymously assesses participation level, prevention knowledge and attitudes, perceptions of coalition group climate, perceptions of prevention-related skills, expectations for coalition efficacy in achieving prevention goals, perceptions of efficacy to implement environmental strategies and member overall satisfaction with the coalition. Data from the coalition member survey will be presented and discussed at a coalition meeting to reinforce areas of strength and identify areas for improvement. In addition, variables can be analyzed for levels of internal cohesion (how well do coalition members share information readily and through multiple channels with one another) and coalition ties to external constituencies which enable the coalition to bring the diverse perspectives of the community to bear in decision-making, and enabling the coalition to reach different community sectors with its messages.

Progress toward implementing objectives will be presented using implementation evaluation data two times a year in state level and community coalition meetings. Discussion at these meetings will focus on identifying and understanding what has been working well and more or less as planned, what has not been working well and has deviated from plan. Unanticipated consequences of project activities, if any, will also be reviewed. The evaluator and project director (at the state level) or coalition coordinator (at the community level) will take the lead in creating a narrative describing these themes. Staff and coalition members in charge of implementing intervention components will use these themes to adjust their plans. The evaluator will compile the lessons learned narratives and periodically examine them for "meta-learning" or themes over time, which might not otherwise be visible.

The CRST and BHDDH affirm that the required process and outcome data will be submitted

through SAMSHA's online reporting platform. BHDDH's requirement that the funded subrecipient communities submit process data into BHDDH's online reporting system quarterly will act as a quality control process, identifying any reporting issues from subrecipient communities early so that they can be corrected promptly prior to SAMSHA's submission deadlines.

All evaluation activities will be guided by a commitment to the principles outlined in SAMSHA's guideline for cultural and linguistic competence and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS). This includes actively considering the potential for disparate outcomes among diverse populations.

Performance Assessment (Evaluation overview at State and Community Levels). The CRST will a design and implement a comprehensive evaluation of the organization, activities, outputs and outcomes of the RI SPF PFS initiative. Comprehensive means this evaluation will be:

1. ***Multi-level.*** The evaluation will document and assess activities, outputs and outcomes at the state level, and at Community levels. The effectiveness of support activities at the state level, including how RIPRC increases capacity at the community level will also be documented and assessed.
2. ***Multi-site.*** The community coalitions will be a primary focus for both process and outcomes evaluation. Each of the community coalitions will be tracked independently with comparable documentation of structures, capacities, implementation processes and outcomes. This will allow multi-site analysis to identify the coalition characteristics that need to be attended to via services from the RIPRC and, eventually, those characteristics that contribute most to success in achieving community outcomes.
3. ***Process-focused.*** The evaluation will document organizational structures at both state and community levels, decision-making procedures, degree of collaboration, outputs of activities and implementation fidelity for both structured curriculum programs as well as less structured environmental change strategies (e.g., developing a social norms campaign, changing local policies).
4. ***Outcome-driven.*** The evaluation will measure the degree to which the state level outcomes of reducing 30-day prevalence of alcohol and marijuana use among 12-17 year olds is produced. We will also measure the degree to which the state achieves system change with respect to data systems, reporting by local communities and the nature and extent of support activities (e.g., training and TA) are effectively provided to communities. The evaluation will also measure the degree to which each coalition improves capacity, changes intermediate variables (aka risk/protective factors, contributing conditions) and ultimately bring about significant changes in community level 30-day prevalence rates. The evaluation will be designed to identify which communities changed, by how much and how these change aggregate to state-level change.
5. ***Participatory / Collaborative.*** The CRST evaluation team will work with BHDDH, the RI SEOW, EBP Workgroup, RIPRC and all local community stakeholders to develop an inclusive, collaborative evaluation in which all stakeholders have a voice; and communities are given relevant and useful support through training, TA, data resources, and regular feedback of evaluation data and findings.

More specifically, in addition to collecting and reporting on the required process and outcome measures described in Section I-2.3 of the RFA, evaluations at both state and community levels

will assess whether BHDDH is achieving its objectives with respect to the SPF PFS grant and where changes or adjustments might need to be made to increase the probability of reaching objectives. The evaluation will address several process and outcome questions at both the State and Community level as described below.

The State-Level process evaluation will address four central questions: (1) was the project implemented as planned; (2) what changes were made during implementation in the approach at the State level or in the manner in which the State provided guidance, coordinator or Training and Technical Assistance to the Community subrecipients; (3) what barriers or challenges were encountered and how were they addressed and (4) what was the type, nature and intensity of support provided by the State via RIPRC to the subrecipient communities. Data for the State-level process evaluation will be drawn form BHDDH records, the BHDDH online reporting system, the project timeline described in Section B that identifies key project activities, milestones and staff responsible for achieving each component and records from the SEOW Workgroup, the EPB Workgroup and the RIPRC Training and Technical Assistance database.

The State-Level outcome evaluation will examine (1) NSDUH and YRBS trends to determine whether the RI SPF-PFS II produces significant changes in 30-day prevalence for the youth population (12-17 years old) statewide and (2) How the State's prevention system infrastructure capacity changed structurally and in terms of process to incorporate SEOW, RIPRC and Evaluation performance data to improve effectiveness in reaching planned outcomes statewide and at the community level.

The Community-Level process evaluation will be guided by four questions: (1) was the local project carried out as proposed; (2) what changes were made, if any, in comparison to the local implementation steps and for what reasons; (3) what challenges, if any, were encountered and how were they address; (4) did the level of service delivery reach the appropriate target populations in a sufficient dose to achieve expected outcomes? Data for answering community-level process evaluation questions will be drawn from subrecipient records, the subrecipient proposal and accompanying implementation plan, local evaluation methods such as community coalition member surveys and leader interviews. Where curricula are being implemented, the local level evaluation will include fidelity measures supplied with the curriculum or adapted for the local evaluation.

The Community-Level outcome evaluation will explore the extent to which the subrecipient community achieved its objectives. This will include (1) whether there were significant reductions in 30-day prevalence of alcohol or marijuana use or both (depending upon local community priorities as identified by the SEOW) from the baseline trends (2) whether or not there were significant changes in intervening variables (e.g., risk and protective factors) associated with 30-day prevalence. Local community evaluations may collect pre, post and follow-up data from selected students who received particular EBP curriculum, track the number of individuals exposed to local media campaigns and media social marketing concerning alcohol and marijuana use and/or document attempts to enact new or revised policies and track related outcomes.

Finally, BHDDH and the CRST affirm that they will submit quarterly progress reports on achievement of the performance measures and an annual report on progress achieved, barriers encountered and efforts to overcome these barriers. As specified in the RFA, these reports will be submitted through SAMHSA's online reporting platform.