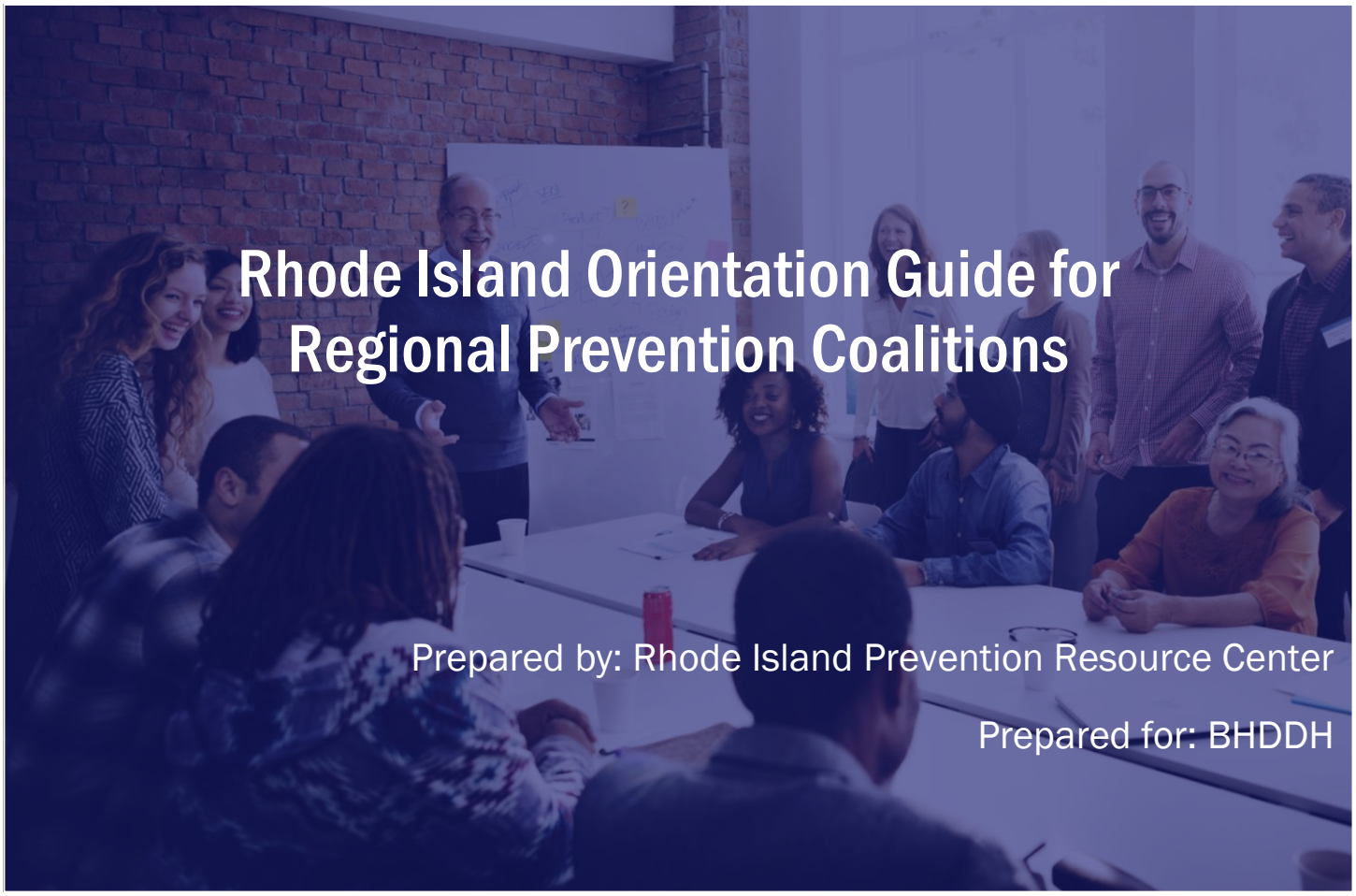


Rhode Island Orientation Guide for Regional Prevention Coalitions

Prepared by: Rhode Island Prevention Resource Center

Prepared for: BHDDH

RIPRC

BHDDH
DEPARTMENT OF BEHAVIORAL HEALTHCARE
DEVELOPMENTAL DISABILITIES & HOSPITALS

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
Division of Behavioral Healthcare
3 Regan Court- 6th Floor
Cranston, RI 02920-3080

TEL: (401) 462-0644
FAX: (401) 462-6078

April 2, 2018

Dear Community Coalition Members:

On behalf of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) we are pleased to welcome you to the new Rhode Island Orientation Guide for Regional Prevention Task Force coalitions. We have created this Guide that includes an overview of prevention and the prevention system in RI as well as coalition operations/functioning, coalition activities and other resources. Our intention is to help orientate coalition coordinators, both municipal and regional, coalition members and staff, especially those who are new to the coalition. The purpose is to provide an overview of prevention coalitions' mission, structure and functioning and key activities, all within the context of the Rhode Island behavioral health system.

Since 1987, the Department has been committed to substance misuse prevention and promoting wellness as part of mental health promotion. We believe in a proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles. Substance use disorders have a serious impact on the quality and function of the lives of individuals, the strength of family support systems and community organization and attachment. Community coalitions are effective agents for public health promotion and assist in the reduction of negative outcomes associated with behavioral health problems

We hope that this Guide will be serve to be a valuable resource for our coalitions and their members statewide.

Sincerely,

Elizabeth T. Farrar

Elizabeth T. Farrar
Associate Administrator
Substance Abuse Prevention Services

ACKNOWLEDGEMENTS & FUNDING STATEMENT

The Rhode Island Orientation Guide for Regional Prevention Task Forces is a resource sponsored by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), for RI prevention providers. The Guide was developed by the Rhode Island Prevention Resource Center (RIPRC). The RIPRC is implemented by JSI Research & Training Institute, Inc. under contract with the BHDDH. Funding for the contract is provided by the Substance Abuse and Mental Health Services Administration (SAMHSA). The content of this Guide does not necessarily represent the views or policies of either SAMHSA or BHDDH.

TABLE OF CONTENTS

INTRODUCTION AND PURPOSE

Introduction

The Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals is dedicated to promoting the health, safety and well-being of all Rhode Islanders by developing policies and programs that address the issues of mental illness, addiction, recovery and community support. The priority of BHDDH is to prevent and reduce the use and misuse of alcohol, tobacco and other drugs across the lifespan. In support of these aims, BHDDH recently created a network of Regional Prevention Task Forces in order to strengthen, synchronize and sustain community-based prevention activities at the local level. The Regional Prevention Task Forces are tasked with overseeing and coordinating the planning and delivery of substance use prevention and behavioral health promotion activities within the municipalities that comprise the region.

BHDDH commissioned the development of this Orientation Guide for Regional Task Forces as a basic reference to assist them in carrying out their charge.

Purpose of the Guide:

This Guide was designed as a basic reference for municipal and Regional Prevention Task Force coordinators, members and staff, especially those who may be new to the RI prevention system. The purpose of the Guide is to provide an overview of the Task Forces' mission, structure and functioning, and key activities, all within the context of the Rhode Island behavioral health system.

The Guide was developed by the Rhode Island Prevention Resource Center (RIPRC) with guidance from BHDDH.

Overview of the Guide:

Section 1 of the Guide summarizes key concepts, approaches and strategies essential to prevention practice, including: public health approaches to prevention in behavioral health; prevention theories and strategies; strategic planning for prevention; and cultural competence in prevention.

Section 2 provides an overview of the RI prevention infrastructure including key players, funding sources and the Rhode Island Strategic Plan for Substance Abuse Prevention.

Section 3 describes the mission, roles and responsibilities of the Regional Prevention Task Forces as well as membership and collaboration with municipal coalitions, and governance.

Section 4 discusses six essential strategies for community prevention initiatives and provides examples of each strategy as put into action by Rhode Island neighborhoods, towns and cities.

The Appendices feature practical tools and resources including a list of acronyms, a glossary of prevention and coalition terms, links to key websites and references.

For More Information:

For information about the behavioral healthcare system in Rhode Island, please contact the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH): 401-462-0644, www.bhddh.ri.gov.

For more information on substance use disorder services and to review Rhode Island's Strategic Plan for Substance Abuse Prevention, visit the BHDDH website, www.bhddh.ri.gov .

For information on training and technical assistance opportunities for Regional and Municipal Prevention Task Forces in Rhode Island, please contact the Rhode Island Prevention Resource Center: www.riprc.org .

PREVENTION IN BEHAVIORAL HEALTH

BHDDH is committed to using SAMHSA's Strategic Prevention Framework (SPF) in developing its policies and programs to prevent and reduce substance misuse among Rhode Islanders. The SPF provides a systematic approach to community-based prevention efforts and helps states and communities build the infrastructure necessary for successful outcomes. Regional Prevention Task Forces and Municipal prevention coalitions in RI utilize this framework to ground and guide the planning and implementation of effective substance abuse prevention initiatives that meet the needs of their communities.

This section of the Orientation Guide offers a mini "Prevention 101" for Task Force members and staff. It summarizes key concepts, approaches and strategies essential to prevention practice in the community, including: public health approaches to prevention in behavioral health; prevention theories and strategies; a brief history of substance abuse prevention in the U.S.; an overview of the Strategic Prevention Framework; and cultural competence in prevention.

What is Behavioral Health?

Behavioral Health refers to "a state of emotional/mental well-being and/or choices and actions that affect health and wellness."

Individuals engage in behavior and make choices that affect their wellness, including whether or not to use alcohol, tobacco or other drugs. Communities can also impact choices and actions that affect wellness, such as imposing and enforcing laws that restrict youth access to alcohol and assuring that all pregnant women have access to prenatal care.

Behavioral health problems include:

- Substance abuse or misuse
- Alcohol and drug addiction
- Mental and substance use disorders
- Serious psychological distress
- Suicide

The term *behavioral health* can also be used to describe the service systems surrounding the promotion of mental health, the prevention and treatment of mental and substance use disorders, and recovery support.

The public health approach and the Institute of Medicine (IOM) Continuum of Care co-exist and both influence the field of prevention in behavioral health.

Public Health Approach

A commonly used definition of ***public health*** from the IOM: "It is what we, as a society, do collectively to assure the conditions for people to be healthy."

Public Health Approach: Key Characteristics

- ✓ **Promotion and prevention** – The focus is on promoting wellness and preventing problems.
- ✓ **Population-based** –The focus is not on one individual but on the population that is affected and that is at risk.
- ✓ **Risk and protective factors** – These are the factors that influence the problem.
- ✓ **Multiple contexts** – Contexts relate to the ecological model in which the individual is influenced by different environments, such as the family, neighborhood, school, community, and culture.
- ✓ **Developmental perspective** – Consider the developmental stage of life of the populations at risk (e.g. adolescence, older adults)
- ✓ **Planning process** – Public health utilizes a deliberate, active, and ongoing planning process.

The Public Health approach to developing prevention intervention and strategies asks the following questions…

What? – What substance use and other behavioral problems need to be addressed?

Who? – Who will the interventions focus on—the entire population or a specific population group?

When? – When in the lifespan—at what specific developmental stage—is the population group that the interventions focus on? (e.g., adolescence, young adulthood)

Where? – Where should the interventions take place? Prevention needs to take place in multiple contexts that influence health and where risk and protective factors can be found—in individuals, families, communities, and society.

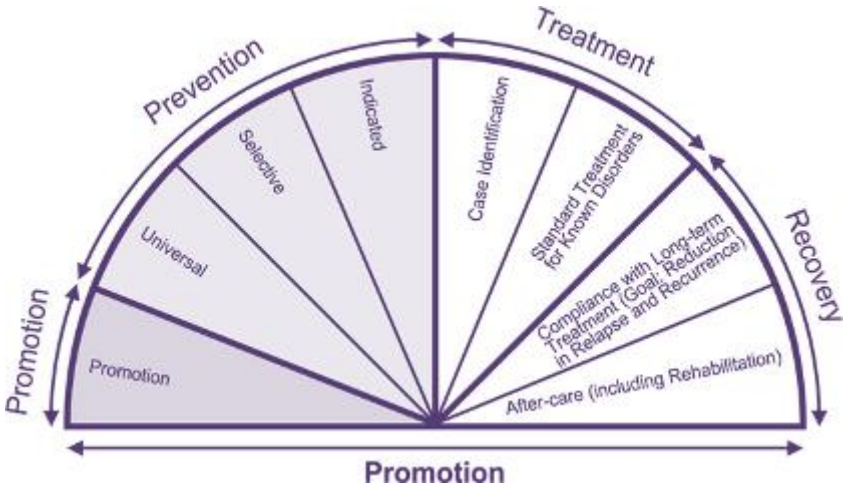
Why? – Why are these problems occurring? This refers to the risk and protective factors that contribute to the problems.

How? – How do we do effective prevention? This refers to a planning process—the Strategic Prevention Framework—that will be used to determine what interventions will be most effective for a specific population group.

Source SAPST, Version 8, November 2012 – SAMHSA Reference #277-08-0218

The IOM Continuum of Care

The Institute of Medicine's continuum of care is a classification system that presents the scope of behavioral health interventions and services, including: promotion of health, prevention of illness/ disorder, treatment, and maintenance/recovery.



Promotion involves interventions (e.g., programs, practices, or environmental strategies) that enable people "to increase control over, and to improve, their health."

Prevention focuses on interventions that occur prior to the onset of a disorder and which are intended to prevent the occurrence of the disorder or reduce risk for the disorder. There are 3 main types of prevention interventions including:

Universal preventive interventions focus on the "general public or a population subgroup that have *not been identified on the basis of risk*."

Examples: community policies that promote access to early childhood education, implementation or enforcement of anti-bullying policies in schools, education for physicians on prescription drug misuse, and social skills education for youth in schools

Selective preventive interventions focus on individuals or subgroups of the population "whose risk of developing behavioral health disorders is significantly higher than average."

Examples: prevention education for new immigrant families living in poverty with young children, and peer support groups for adults with a history of family mental illness and/or substance abuse

Indicated preventive interventions focus on "high-risk individuals who are identified as having minimal but detectable signs or symptoms" that foreshadow behavioral health disorders, "but who do not meet diagnostic levels at the current time."

Examples: information and referral for young adults who violate campus or community policies on alcohol and drugs; and screening, consultation, and referral for families of older adults admitted to emergency rooms with potential alcohol-related injuries

Treatment interventions include case identification and standard forms of treatment (e.g., detoxification, outpatient treatment, in-patient treatment, medication-assisted treatment).

Maintenance includes interventions that focus on compliance with long-term treatment to reduce relapse and recurrence, and aftercare including rehabilitation and recovery support.

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Source: SAPST, Version 8, November 2012 – SAMHSA Reference #277-08-0218

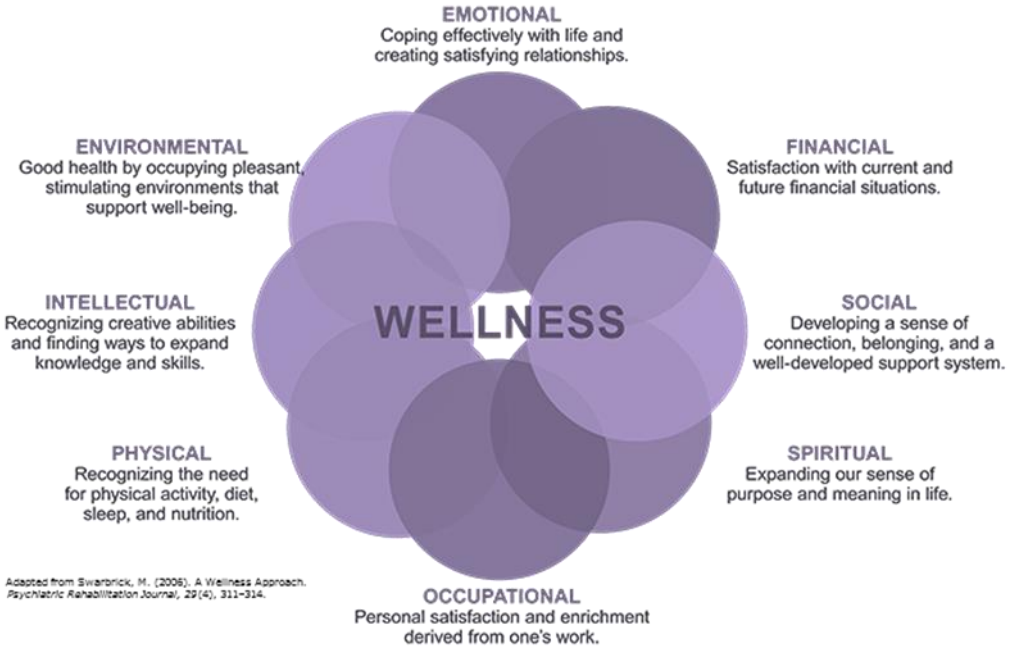
The Ultimate Goal of Prevention Activities is Wellness.

Wellness is a conscious, deliberate process that requires awareness of—and making choices for—a more gratifying lifestyle.

Wellness is not merely the absence of disease, illness, and stress, but the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness.

Eight Dimensions of Wellness

SAMHSA (the Substance Abuse and Mental Health Services Administration) describes wellness as having eight dimensions:



History of Substance Abuse/Misuse Prevention

DATE	NATIONAL SITUATION	PREVENTION STRATEGY
1950s	Drug use intensified. Heroin addiction alone hit an all-time high, particularly in urban areas.	Scare tactics through films and speakers
1960s	People began using drugs to have psychedelic experiences. Drug use was associated with the counter culture or racial/ethnic minorities. By the end of the decade, drug use was considered a national epidemic.	Scare tactics through films and speakers; information about substance abuse through films and speakers
1970s	Alcohol and drug abuse were recognized as major public health problems. War on Drugs campaign was developed to reduce illegal drug trade. Throughout the decade, society grew more tolerant of drug use.	Drug education using curricula based on factual information; affective education using curricula based on communication, decision- making, values clarification, and self-esteem
1980s	"Just Say No" campaign, part of the War on Drug effort, encouraged youth to resist peer pressure by saying "no." Partnerships developed as the public became increasingly involved in addressing the problems of substance abuse.	Parent-formed organizations to combat drug abuse, social skills curricula, refusal skill training and parenting education
1990s	Research examined the factors that protect people or put them at risk for a variety of problems, including alcohol and drug abuse. The value of professionalism and training in this area grew. Community collaborations received funding to address alcohol and drug problems.	Community-based approaches to prevention; environmental approaches; media campaigns; culturally sensitive programs; evaluation of prevention programs; professional training programs
2000–2010	Understanding of the connections between substance abuse and mental illness/health evolved. "Behavioral health" encompassed both substance use and mental health problems.	Application of evidence-based models; comprehensive programs targeting many contexts (family, school, community); data-driven decision-making through a strategic planning process
2010–present	Greater emphasis is placed on prevention and treatment for everyone. Behavioral health was integrated with primary care under the Affordable Care Act of 2010.	Use of evidence-based practices; strategic planning process; improved access to health insurance with better benefits for mental health and substance abuse services and support

PREVENTION THEORIES AND STRATEGIES

Risk and Protective Factor Theory

Many factors influence the likelihood that an individual will develop a substance abuse or related behavioral health problem. Effective prevention focuses on reducing the factors that put people at risk of behavioral health disorders and strengthening those factors that protect people from these disorders.

Risk factors are certain biological, psychological, family, community, or cultural characteristics that precede and are associated with a higher likelihood of behavioral health problems.

Protective factors are characteristics at the individual, family, or community level that are associated with a lower likelihood of problem outcomes.

Risk and protective factors exist in multiple domains, including:

- *Individual level:* Examples of Individual level risk factors include genetic predisposition to addiction or exposure to alcohol prenatally; protective factors include positive self-image, self-control, or social competence.
- *Family level:* Examples of Family level risk factors include child abuse and maltreatment, inadequate supervision, and parents who use drugs and alcohol or who suffer from mental illness; a protective factor would be parental involvement.
- *Community level:* Examples of Community level risk factors include neighborhood poverty and violence; protective factors might include the availability of faith-based resources and afterschool activities.
- *Society level:* Examples of Society level risk factors include norms and laws favorable to substance use, as well as racism and a lack of economic opportunity; protective factors include policies limiting availability of substances or laws protecting marginalized populations, such as lesbian, gay, bisexual, or transgender youth.

In prevention, it is important to address the constellation of factors across these domains that influence both individuals and populations.

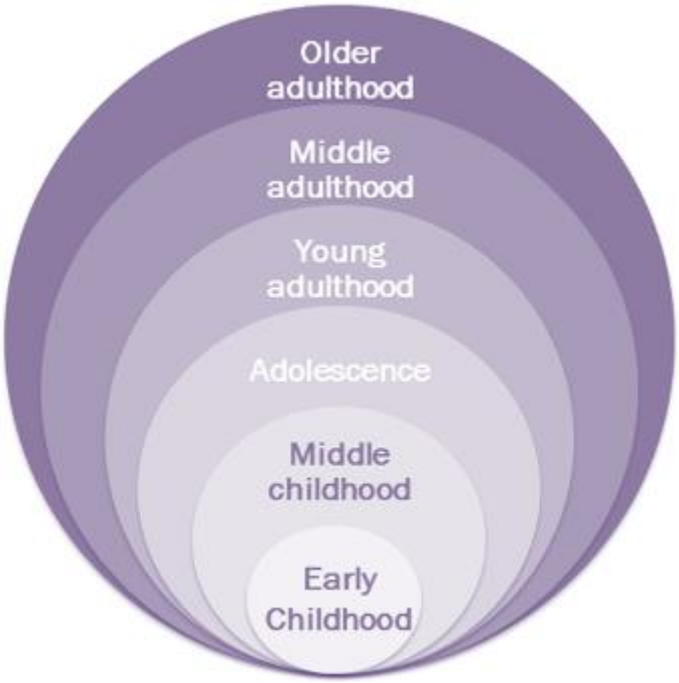
Source: SAPST Info Sheet 1.8, SAPST Version 8, November 2012 – SAMHSA Reference #277-08-0218

Developmental Perspective

As children grow, they progress through a series of developmental periods. Each period is associated with a specific set of developmental competencies: cognitive, emotional, and behavioral abilities. Adults have developmental phases as well. A "developmental perspective" considers the developmental stage of life of the individuals that are the focus of interventions to improve health and prevent disease.

The developmental perspective looks at risk and protective factors and their potential consequences and benefits according to defined developmental periods.

- Different age groups have different risk and protective factors. Some risk and protective factors overlap age groups, although the risk and protective factors for adulthood vary from those for childhood.
- People must learn to adapt to new challenges and experiences in each developmental period. Certain risk and protective factors affect healthy development at different periods.
- Trauma and stressful life events can occur during any period of development; however, trauma in youth can impact adult development.



- Transitioning from one stage to another brings new stresses.
- Development might look different in different cultures and with people who have disabilities.

Understanding the developmental perspective is important to substance use prevention because:

- Interventions should be appropriate for the specific developmental stage of the population they target.
- Prevention efforts that are aligned with key periods in young peoples' development are most likely to produce the desired, long-term positive effects.
- People are more vulnerable to substance abuse and other behavioral health problems when they have experienced untreated, unresolved trauma.

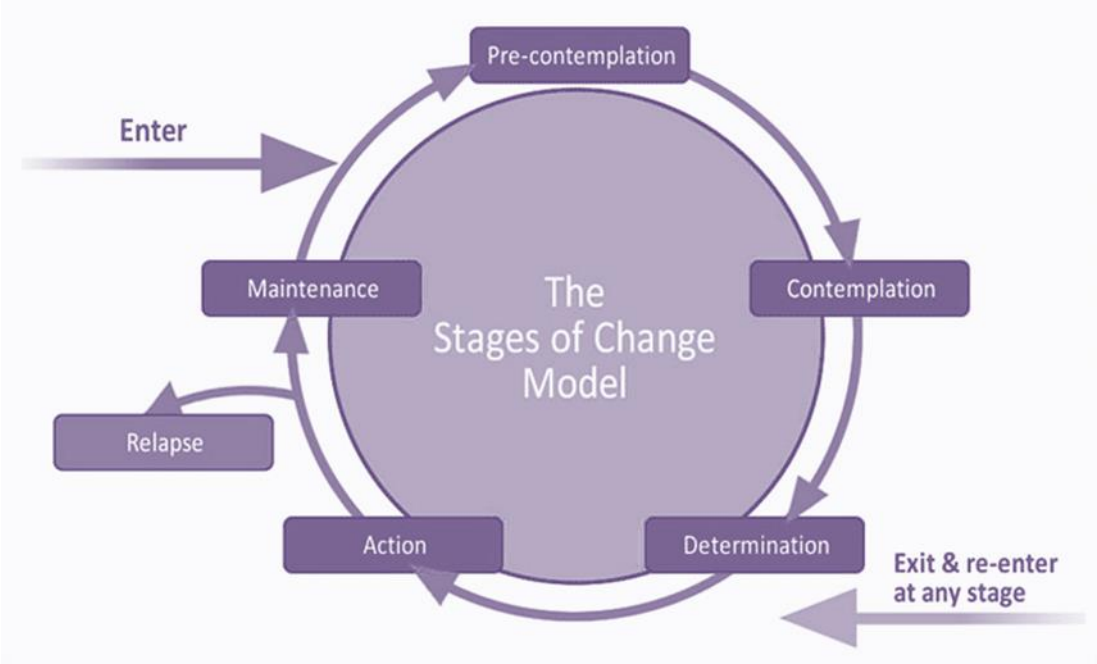
Source: SAPST Version 8, November 2012 – SAMHSA Reference #277-08-0218

Stages of Change

The Stages of Change Model developed by Prochaska and DiClemente (1982) describes the process people go through in modifying a problem behavior.

The model was developed with and for people with substance use disorders, but is applicable to all kinds of behavior change, especially health behavior change.

Stages of Change Model



Source: Johnny Holland. (2011). Stages of Change Model by Prochaska & DiClemente.

The five stages of change are:

- Pre-contemplation
- Contemplation
- Preparation/Determination
- Action
- Maintenance

Relapse (going back to a former behavior or earlier stage) is always possible.

In the process of changing behavior, people move through the stages NOT in a linear way, but cycling between stages. People can learn from relapse/reoccurrence about what to do to sustain a change.

Pre-contemplation: The person does not see the behavior as a problem/does not see a need for change/has no intention to change.

Contemplation: The person has some awareness of the need/desire to change behavior and is actively weighing the pros and cons of the behavior.

Preparation: The person believes that the behavior can be changed and that he/she can manage the change and is taking steps to get ready to make the change.

Action: The person has begun to make the behavior change and has developed plans to maintain the change.

Maintenance: The person has maintained the new behavior consistently for over 6 months and has made the new behavior habitual.

Relapse: The person has a "slip"- reverts back to a previous pattern of behavior. The person may become discouraged but should recognize that most people making a behavior change have some degree of reoccurrence.

Source: Rhode Island Behavioral Health Peer Recovery Specialist curriculum, (2015) Day 5

Broad Types of Prevention Strategies

Some types of prevention strategies focus on changing individuals, while others focus on changing the environment in some way.

Individual behavior change strategies

Strategies focused on changing individual's behavior include:

- **Education-based programs** that focus on helping people develop the knowledge, attitudes, and skills they need to change their behavior. Education-based programs may be targeted at young people, parent, merchants, and servers among others.
- **School and community bonding activities** address the risk factor of low attachment to school and community. Specific interventions can include mentoring and alternative activities, such as opportunities for positive social interaction.
- **Communication and public education** involves the media because of the significant role it plays in shaping how people think and behave. Many of the messages on television, billboards, the Internet, as well as in music and magazines, glamorize drug, alcohol, and tobacco use. Yet, the media can be used to encourage positive behaviors, as well.

Source: Info Sheet 3.11 SAPST Version 8, November 2012 – SAMHSA Reference #277-08-0218

Environmental Strategies

Environmental strategies are prevention efforts aimed at changing or influencing community conditions, standards, institutions, structures, systems and policies. Environmental strategies enhance public health by altering the physical, social, legal, and economic conditions that influence behavior.

Strategies focused on changing the community environmental context that influence individual behavior include those that:

- **Enhance access/reduce barriers** —Improving systems and processes to increase the ease, ability and opportunity to utilize systems and services (e.g. access to treatment, childcare, transportation, housing, education, cultural and language sensitivity). This strategy can be utilized when it is turned around to reducing access/enhancing barriers.

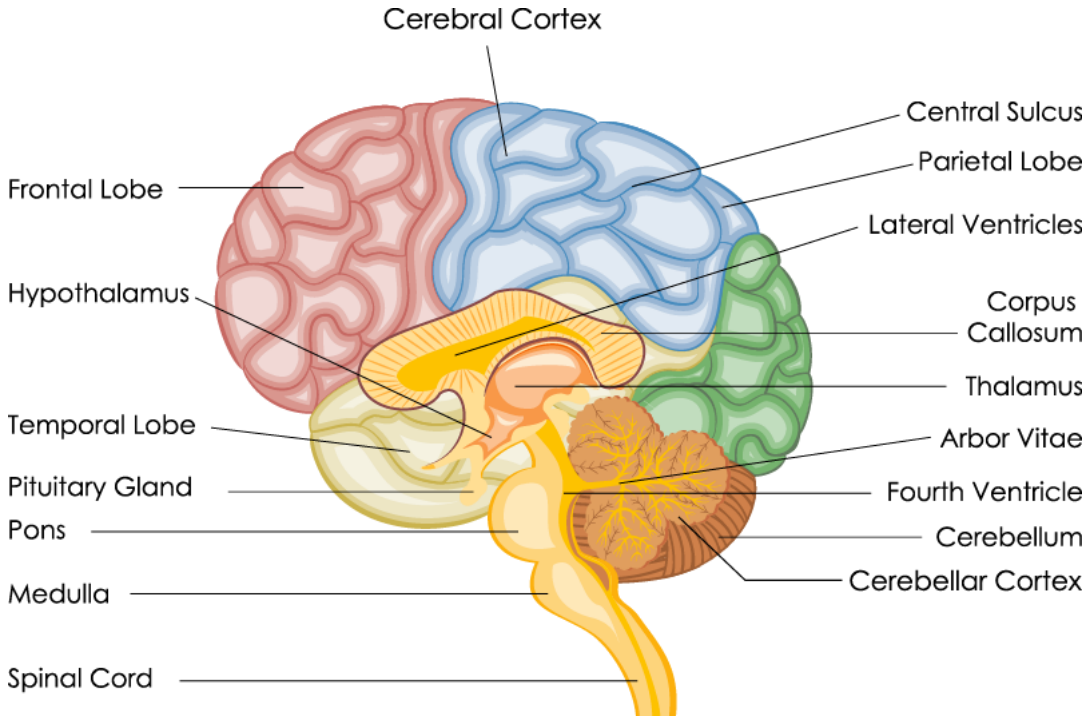
- **Change consequences (incentives/disincentives)**—Increasing or decreasing the probability of a specific behavior that reduces risk or enhances protection by altering the consequences for performing that behavior (e.g., increasing public recognition for deserved behavior, individual and business rewards, taxes, citations, fines, revocations/loss of privileges).

- **Change physical design**—Changing the physical design or structure of the environment to reduce risk or enhance protection (e.g., parks, landscapes, signage, lighting, outlet density).

- **Modify/change policies**—Formal change in written procedures, by-laws, proclamations, rules or laws with written documentation and/or voting procedures (e.g., workplace initiatives, law enforcement procedures and practices, public policy actions, systems change within government, communities and organizations).

Source: The Coalition Impact: Environmental Prevention Strategies, CADCA 2010

ALCOHOL, TOBACCO & OTHER DRUGS – EFFECTS ON THE BRAIN



The brain is made up of many parts that all work together as a team. Different parts of the brain are responsible for coordinating and performing specific functions. Drugs can alter important brain areas that are necessary for life sustaining functions and can drive the compulsive drug abuse that marks addiction. Brain areas affected by drug abuse include:

- The **brain stem**, which controls basic functions critical to life, such as heart rate, breathing, and sleeping.
- The **cerebral cortex**, which is divided into areas that control specific functions. Different areas process information from our senses, enabling us to see, feel, hear, and taste. The front part of the cortex, the frontal cortex or forebrain, is the thinking center of the brain; it powers our ability to think, plan, solve problems, and make decisions.
- The **limbic system**, which contains the brain's reward circuit. It links together a number of brain structures that control and regulate our ability to feel pleasure. Feeling pleasure motivates us to repeat behaviors that are critical to our existence. The limbic system is activated by healthy, life sustaining activities such as eating and socializing—but it is also activated by drugs of abuse. In addition, the limbic system is responsible for our perception of other emotions, both positive and negative, which explains the mood-altering properties of many drugs.

Source: National Institute of Drug Abuse. (2008). Drugs, Brains, and Behavior: The Science of Addiction.

COMMONLY ABUSED DRUGS

Visit NIDA at www.drugabuse.gov

NIDA NATIONAL INSTITUTE ON DRUG ABUSE

Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**	*Intoxication Effects*/Potential Health Consequences
Cannabinoids			*euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination/cough, frequent respiratory infections; impaired memory and learning; increased heart rate, anxiety, panic attacks; tolerance, addiction*
hashish	boom, chronic, gangster, hash, hash oil, hemp	I/swallowed, smoked	
marijuana	blunt, dope, ganja, grass, herb, joints, Mary Jane, pot, reefer, sinsemilla, skunk, weed	I/swallowed, smoked	
Depressants			*reduced anxiety; feeling of well-being; lowered inhibitions; slowed pulse and breathing; lowered blood pressure; poor concentration/fatigue; confusion, impaired coordination, memory, judgment; addiction; respiratory depression and arrest; death*
barbiturates	*Amytal, Nembutal, Seconal, Phenobarbital:* barbs, reds, red birds, phennies, tooies, yellows, yellow jackets	II, III, V/injected, swallowed	*Also, for barbiturates—sedation, drowsiness/depression, unusual excitement, fever, irritability, poor judgment, slurred speech, dizziness, life-threatening withdrawal*
benzodiazepines (other than flunitrazepam)	*Ativan, Halcion, Librium, Valium, Xanax:* candy, downers, sleeping pills, tranks	IV/swallowed, injected	*for benzodiazepines—sedation, drowsiness/dizziness*
flunitrazepam***	*Rohypnol:* forget-me pill, Mexican Valium, R2, Roche, roofies, roofinol, rope, rophies	IV/swallowed, snorted	*for flunitrazepam—visual and gastrointestinal disturbances, urinary retention, memory loss for the time under the drug's effects*
GHB***	*gamma-hydroxybutyrate:* G, Georgia home boy, grievous bodily harm, liquid ecstasy	I/swallowed	*for GHB—drowsiness, nausea/vomiting, headache, loss of consciousness, loss of reflexes, seizures, coma, death*
methaqualone	*Quaalude, Sopor, Parest:* ludes, mandrex, quad, quay	I/injected, swallowed	*for methaqualone—euphoria/depression, poor reflexes, slurred speech, coma*
Dissociative Anesthetics			*increased heart rate and blood pressure, impaired motor function/memory loss; numbness; nausea/vomiting*
ketamine	*Ketalar SV:* cat Valiums, K, Special K, vitamin K	III/injected, snorted, smoked	*Also, for ketamine—at high doses, delirium, depression, respiratory depression and arrest*
PCP and analogs	*phencyclidine:* angel dust, boat, hog, love boat, peace pill	I, II/injected, swallowed, smoked	*for PCP and analogs—possible decrease in blood pressure and heart rate, panic, aggression, violence/loss of appetite, depression*
Hallucinogens			*altered states of perception and feeling; nausea; persisting perception disorder (flashbacks)*
LSD	*lysergic acid diethylamide:* acid, blotter, boomers, cubes, microdot, yellow sunshines	I/swallowed, absorbed through mouth tissues	*Also, for LSD and mescaline—increased body temperature, heart rate, blood pressure; loss of appetite, sleeplessness, numbness, weakness, tremors*
mescaline	buttons, cactus, mesc, peyote	I/swallowed, smoked	*for LSD—persistent mental disorders*
psilocybin	magic mushroom, purple passion, shrooms	I/swallowed	*for psilocybin—nervousness, paranoia*
Opioids and Morphine Derivatives			*pain relief, euphoria, drowsiness/nausea, constipation, confusion, sedation, respiratory depression and arrest, tolerance, addiction, unconsciousness, coma, death*
codeine	*Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine:* Captain Cody, Cody, schoolboy; (with glutethimide) doors & fours, loads, pancakes and syrup	II, III, IV, V/injected, swallowed	*Also, for codeine—less analgesia, sedation, and respiratory depression than morphine*
fentanyl and fentanyl analogs	*Actiq, Duragesic, Sublimaze:* Apache, China girl, China white, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash	I, II/injected, smoked, snorted	*for heroin—staggering gait*
heroin	*diacetylmorphine:* brown sugar, dope, H, horse, junk, skag, skunk, smack, white horse	I/injected, smoked, snorted	
morphine	*Roxanol, Duramorph:* M, Miss Emma, monkey, white stuff	II, III/injected, swallowed, smoked	
opium	*laudanum, paregoric:* big O, black stuff, block, gum, hop	II, III, V/swallowed, smoked	
oxycodone HCL	*OxyContin:* Oxy, O.C., killer	II/swallowed, snorted, injected	
hydrocodone bitartrate, acetaminophen	*Vicodin:* vike, Watson-387	II/swallowed	
Stimulants			*increased heart rate, blood pressure, metabolism; feelings of exhilaration, energy; increased mental alertness/rapid or irregular heart beat; reduced appetite, weight loss, heart failure, nervousness, insomnia*
amphetamine	*Biphetamine, Dexedrine:* bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II/injected, swallowed, smoked, snorted	*Also, for amphetamine—rapid breathing/tremor, loss of coordination; irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness, tolerance, addiction, psychosis*
cocaine	*Cocaine hydrochloride:* blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II/injected, smoked, snorted	*for cocaine—increased temperature/chest pain, respiratory failure, nausea, abdominal pain, strokes, seizures, headaches, malnutrition, panic attacks*

*Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (unrefillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally. Some Schedule V drugs are available over the counter.

**Taking drugs by injection can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms.

***Associated with sexual assaults.

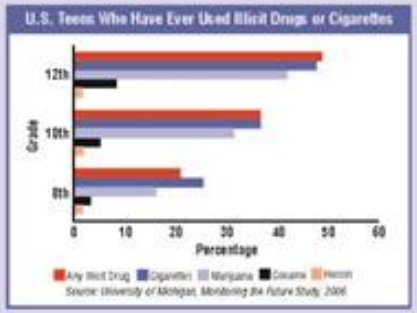
2/07

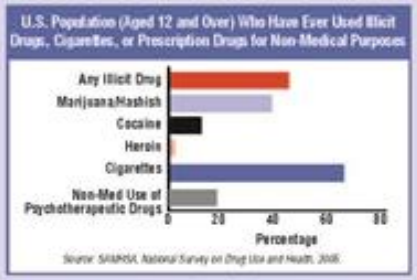
Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**	*Intoxication Effects*/Potential Health Consequences
Stimulants (continued)			
MDMA (methyl-enedioxymeth-amphetamine)	Adam, clarity, ecstasy, Eve, lover's speed, peace, STP, X, XTC	I/swallowed	*for MDMA—mild hallucinogenic effects, increased tactile sensitivity, empathic feelings*/impaired memory and learning, hyperthermia, cardiac toxicity, renal failure, liver toxicity
methamphetamine	*Desoxyn:* chalk, crank, crystal, fire, glass, go fast, ice, meth, speed	II/injected, swallowed, smoked, snorted	*for methamphetamine—aggression, violence, psychotic behavior*/memory loss, cardiac and neurological damage; impaired memory and learning, tolerance, addiction
methylphenidate (safe and effective for treatment of ADHD)	*Ritalin:* JIF, MPH, R-ball, Skippy, the smart drug, vitamin R	II/injected, swallowed, snorted	*for nicotine—additional effects attributable to tobacco exposure:* adverse pregnancy outcomes; chronic lung disease, cardiovascular disease, stroke, cancer; tolerance, addiction
nicotine	cigarettes, cigars, smokeless tobacco, snuff, spit tobacco, bidis, chew	not scheduled/smoked, snorted, taken in snuff and spit tobacco	
Other Compounds			
anabolic steroids	*Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise:* roids, juice	III/injected, swallowed, applied to skin	*no intoxication effects*/hypertension, blood clotting and cholesterol changes, liver cysts and cancer, kidney cancer, hostility and aggression, acne; in adolescents, premature stoppage of growth; in males, prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females, menstrual irregularities, development of beard and other masculine characteristics
Dextromethorphan (DXM)	Found in some cough and cold medications; Robotripping, Robo, Triple C	not scheduled/swallowed	*Dissociative effects, distorted visual perceptions to complete dissociative effects*/for effects at higher doses see 'dissociative anesthetics'
inhalants	*Solvents (paint thinners, gasoline, glues), gases (butane, propane, aerosol propellants, nitrous oxide), nitrites (isoamyl, isobutyl, cyclohexyl):* laughing gas, poppers, snappers, whippets	not scheduled/inhaled through nose or mouth	*stimulation, loss of inhibition; headache; nausea or vomiting; slurred speech, loss of motor coordination; wheezing*/unconsciousness, cramps, weight loss, muscle weakness, depression, memory impairment, damage to cardiovascular and nervous systems, sudden death

Principles of Drug Addiction Treatment

More than three decades of scientific research have yielded 13 fundamental principles that characterize effective drug abuse treatment. These principles are detailed in NIDA's *Principles of Drug Addiction Treatment: A Research-Based Guide.*

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each patient's problems and needs is critical.
2. **Treatment needs to be readily available.** Treatment applicants can be lost if treatment is not immediately available or readily accessible.
3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.** Treatment must address the individual's drug use and associated medical, psychological, social, vocational, and legal problems.
4. **At different times during treatment, a patient may develop a need for medical services, family therapy, vocational rehabilitation, and social and legal services.**
5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The time depends on an individual's needs. For most patients, the threshold of significant improvement is reached at about 3 months in treatment. Additional treatment can produce further progress. Programs should include strategies to prevent patients from leaving treatment prematurely.
6. **Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships.
7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** Buprenorphine, methadone, and levo-alpha-acetylmethadol (LAAM) help persons addicted to opiates stabilize their lives and reduce their drug use. Naltrexone is effective for some opiate addicts and some patients with co-occurring alcohol dependence. Nicotine patches or gum, or an oral medication, such as bupropion, can help persons addicted to nicotine.
8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.**
9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.** Medical detoxification manages the acute physical symptoms of withdrawal. For some individuals it is a precursor to effective drug addiction treatment.
10. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase treatment entry, retention, and success.
11. **Possible drug use during treatment must be monitored continuously.** Monitoring a patient's drug and alcohol use during treatment, such as through urinalysis, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that treatment can be adjusted.
12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place them or others at risk of infection.** Counseling can help patients avoid high-risk behavior and help people who are already infected manage their illness.
13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Participation in self-help support programs during and following treatment often helps maintain abstinence.





Order NIDA publications from NCADI:
1-800-729-6686
or TDD: 1-800-487-4889

STRATEGIC PLANNING FOR PREVENTION

Strategic Prevention Framework Basics

A strategic planning process is needed in order to systematically define the behavioral health problems in a given community and to determine what interventions will be most effective for addressing the specific problems in a particular community.

In the United States, prevention professionals use SAMHSA's **Strategic Prevention Framework (SPF)** to plan prevention initiatives. The SPF is a 5-step planning process that guides the selection, implementation, and evaluation of evidence-based, culturally appropriate, sustainable prevention activities. The SPF begins with a clear understanding of community needs and depends on the involvement of community members in all stages of the planning process.

Source: SAMHSA website

The five steps of the SPF include:

1. **Assessment**: Collect data to define behavioral health problems and needs within a geographic area.

2. **Capacity**: Mobilize and/or build capacity within a geographic area to address identified needs.

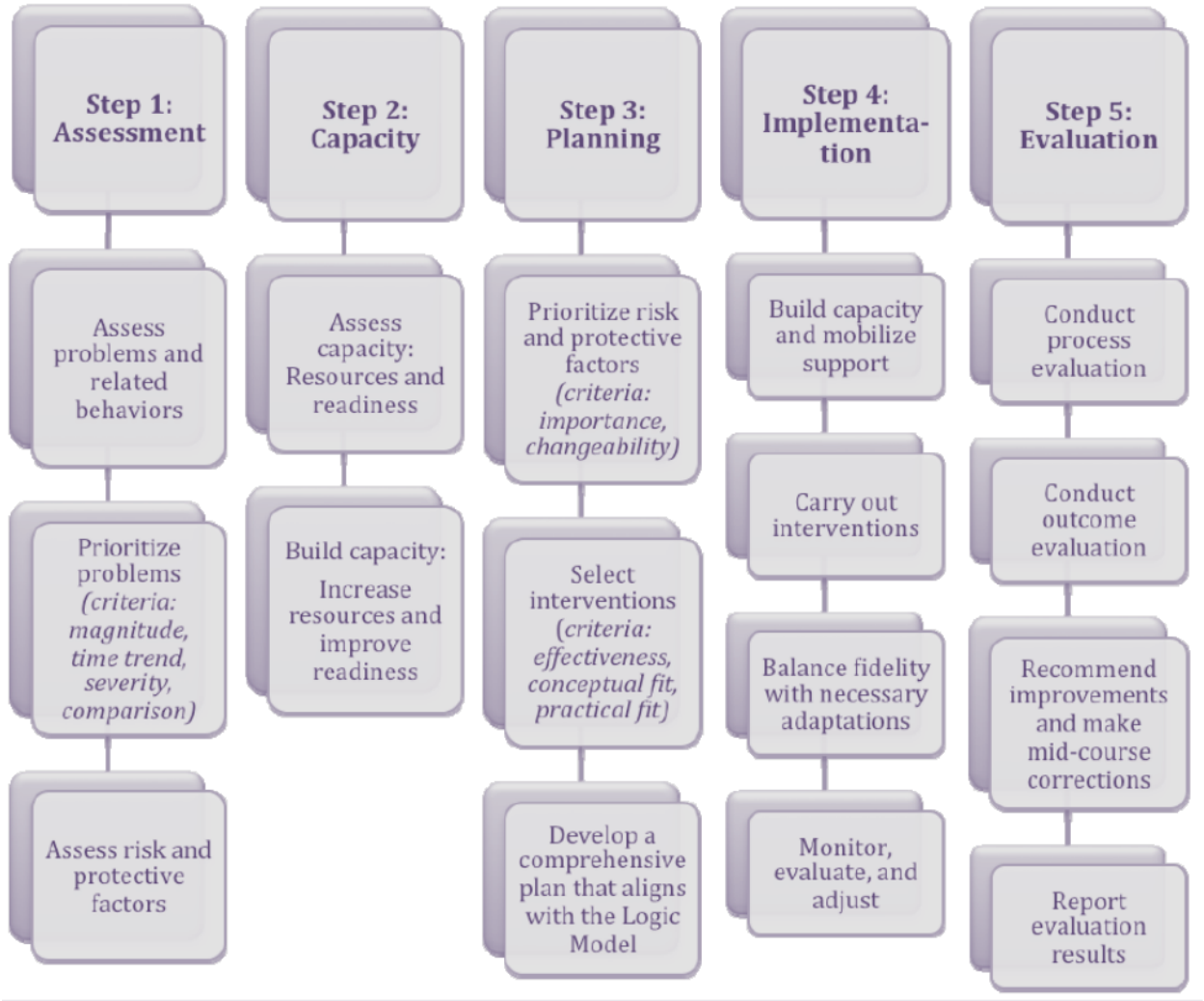
3. **Planning**: Develop a comprehensive, data-driven plan to address problems and needs identified in assessment phase.

4. **Implementation**: Implement evidence-based prevention programs, policies, and practices.

5. **Evaluation**: Measure the impact of implemented programs, policies and practices.

Sustainability and cultural competence should be integrated into all steps of the SPF.

Strategic Prevention Framework at-a-glance



Assessment

Assessment helps communities better understand the behavioral health problem they seek to prevent. The assessment step is sometimes referred to as "needs assessment."

In the assessment step, data are gathered to help answer the following questions:

- What are the problems and related behaviors that are occurring in the community?
- How often are the problems and related behaviors occurring?
- Where are the problems and related behaviors occurring?
- Which populations are experiencing more of the problems and related behaviors?

In the assessment step, data may also be collected on the risk and protective factors that influence the target problem(s).

Capacity

Capacity refers to resources and readiness:

- The **resources** (programs, organizations, people, money, expertise, etc.) a community has to address its substance abuse problems
- How **ready** the community is to take action and commit its resources to addressing these problems

This step in the SPF involves both assessing capacity and improving capacity.

Planning

Good planning requires collaboration and must reflect ideas and input from various sectors within the community, particularly on the population group that the intervention will focus.

Planning encompasses the following tasks:

1. Prioritize risk and protective factors associated with the identified priority.

2. Select prevention interventions that are evidence based, most likely to influence the identified risk factors (conceptual fit), and feasible and relevant to focus population (practical fit).

3. Develop a comprehensive, data driven prevention plan.

Implementation

Implementation encompasses three main tasks:

1. Mobilize support for your efforts and build capacity around implementation.

2. Implement evidence-based programs, policies, and practices, paying specific attention to adaptation and fidelity issues.

3. Monitor implementation, collect evaluation data, and make mid-course corrections based on what the results show.

Evaluation

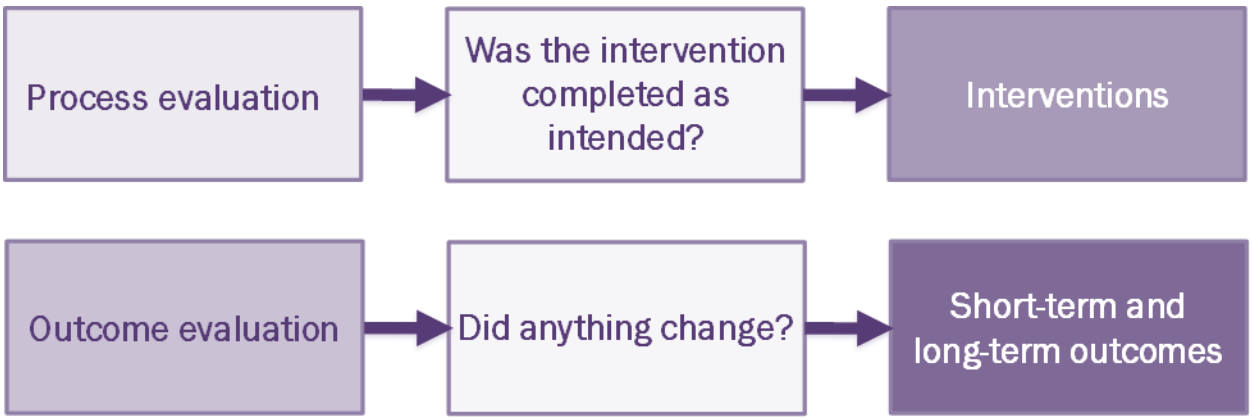
Evaluation is the systematic collection and analysis of information about an intervention to improve its effectiveness and make program decisions.

Evaluation:

- Helps to assess the progress of an intervention
- Identifies what does and does not work in a particular setting
- Is used to improve implementation and performance
- Helps determine which interventions and outcomes should be sustained

Types of Evaluation

Evaluation of prevention programs should collect both process and outcome evaluation data. Process evaluation occurs *during* the implementation of an intervention; outcome evaluation occurs *after* the intervention has been implemented, and may include archival data.

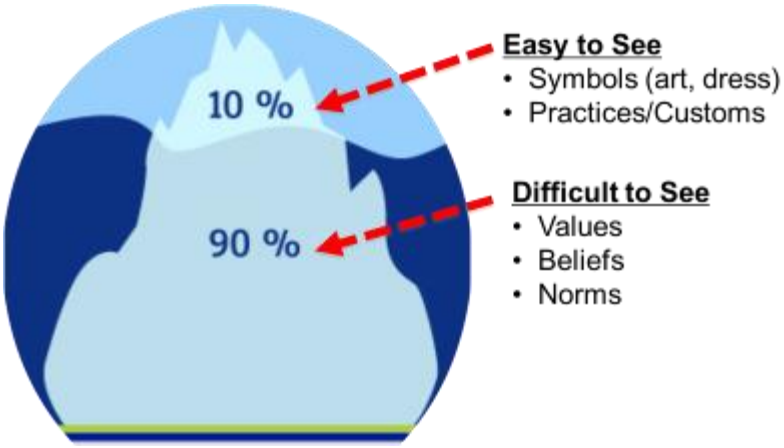


Process evaluation answers the question: "Did we do what we said we would do?" It describes how the intervention was implemented.

Outcome evaluation answers the question: "Did our intervention make a difference—did it impact the risk factors and problem we wanted to address?" It documents effects achieved *after* the intervention is implemented, such as short- and long-term changes in a population group's knowledge, attitudes, skills, or behavior.

CULTURAL COMPETENCE IN PREVENTION

In order for people to benefit from prevention and wellness programs and strategies, it is essential that these interventions fit with their culture—with their values, customs, beliefs, roles, manners of interacting, communication styles, etc. People typically think of culture in terms of race or ethnicity, but culture also refers to other social groups that are defined by age, gender, religion, income level, education, geographical location, sexual orientation, and disability, etc.



Source: Griswold, W. (2008). Cultures and societies in a changing world (3rd ed.). Thousand Oaks, CA: Pine Forge Press.

What is culture?

Culture refers to "integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups." (OMH, US DHHS)

The elements of culture:

- **Norms** – how people behave
- **Values** – what is important to people
- **Beliefs** – what people think about something
- **Symbols** – how people express themselves through art, stories, music, language, etc.
- **Practices** – customs or patterns of behavior that may not be connected to beliefs and values

History and personal experience also shape these elements.

Source: SAPST curriculum

Cultural Competence (as defined by SAMHSA/CAPT)

Cultural competence describes the ability of an individual or organization to interact effectively with people of different cultures. To produce positive change, prevention practitioners must understand the cultural context of their target community, and have the willingness and skills to work within this context. This means drawing on community-based values, traditions, and customs, and working with knowledgeable persons of and from the community to plan, implement, and evaluate prevention activities.

SAMHSA's Center for Substance Abuse Prevention (CSAP) has identified these principles of cultural competence:

- Ensure community involvement in all areas
- Use a population-based definition of community (that is, let the community define itself)
- Stress the importance of relevant, culturally-appropriate prevention approaches
- Employ culturally-competent evaluators
- Promote cultural competence among program staff and hire staff that reflect the community they serve
- Include the target population in all aspects of prevention planning

Source: SAMHSA CAPT webpages

Culturally Competent Organizations

Cultural competence applies to organizations and health systems, just as it does to professionals.

A culturally competent organization:

- Continually assesses organizational diversity
- Invests in building capacity for cultural competency and inclusion
- Practices strategic planning that incorporates community culture and diversity
- Implements prevention strategies using culture and diversity as a resource
- Evaluates the incorporation of cultural competence

Source: SAPST Information Sheet 3.5 Version 8, November 2012 – SAMHSA Reference #277-08-02

OVERVIEW OF THE PREVENTION SYSTEM IN RHODE ISLAND

This section provides an overview of the RI prevention infrastructure including key players, funding sources and the Rhode Island Strategic Plan for Substance Abuse Prevention.

Statewide Agencies and Organizations:

BHDDH

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is the single state authority for substance abuse prevention and treatment. BHDDH's mission is to serve Rhode Islanders who live with mental illness, substance use disorder and/or a developmental disability by maintaining a system of high-quality, safe, affordable and coordinated care across the spectrum of behavioral health care services, and to develop innovative, evidence-based policies and programs that address the issues of mental illness, addiction, recovery and community support. Within BHDDH, the Division of Behavioral Healthcare Services (DBH) maintains overall responsibility for planning, coordinating, administering and monitoring a comprehensive statewide system of mental health and substance abuse prevention, intervention and treatment activities and services.

The Rhode Island Governor's Council on Behavioral Health

The State's behavioral health planning council serves in an advisory capacity to the Governor and the General Assembly. It was established by both federal and State law to review and evaluate the needs and problems associated with Rhode Island's services for individuals with mental health and substance use disorders. In addition, the Council stimulates and monitors the development, coordination, and integration of statewide services. Council members may be behavioral healthcare service providers, consumers of these services, their family members, individuals in recovery from mental illness or substance use disorders, behavioral healthcare advocates or other interested parties. Representatives from State departments are also members, but do not vote. Council meetings are open to the public.

> The Council's **Prevention Advisory Committee (PAC)** provides recommendations which are integrated into the Council's annual report to the Governor and to the state's federal block grant application. The Committee's goals include broadening the focus of substance abuse prevention efforts, reaching populations that have been hard to reach, working to eliminate health disparities and stigma around mental health and substance abuse disorders, and strengthening and expanding the prevention workforce in Rhode Island.

The Rhode Island Prevention Resource Center (RIPRC)

Provides training, technical assistance, and capacity-building resources to Rhode Island substance abuse prevention providers and their community partners. The RIPRC's primary goals are to: Strengthen the capacity of prevention providers and communities to implement current, evidence-based prevention strategies, increase the number of prevention providers who participate in the RI Substance Abuse Prevention certification system, and foster collaboration between substance abuse providers and across related state and local initiatives to prevent substance abuse and other risk-taking behaviors in Rhode Island. The RIPRC is a contract with JSI Research and Training Institute, Inc.

The Rhode Island State Epidemiology Outcomes Workgroup (SEOW)

Examines, interprets, and applies data to inform state and community-level planning for prevention of substance abuse and promotion of mental wellness. The SEOW develops state and community epidemiologic profiles on substance use and mental health in RI, integrating prevalence and incidence data with risk and protective factor data. With BHDDH-administered authority, the Department of Community Health at Brown University performs epidemiological analyses, and the University of Rhode Island, Department of Psychology provides prevention evaluation services for BHDDH.

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. RISAS is implementing Project SUCCESS, an evidence-based SAMHSA program, in over 40 Rhode Island middle and high schools. RISAS goals are to: enhance the resiliency of adolescents whose parents are substance abusers; delay adolescents' initial use of alcohol, tobacco and other drugs; and decrease adolescents' use of alcohol, tobacco and other drugs. This early detection and intervention approach has proven effective in delaying the initiation and use of alcohol and other drugs, and reducing the resultant school and life problems.

RISAS student assistance counselors teach a classroom-based prevention education series, run school-wide awareness activities and provide confidential short-term individual and group counseling services for students on an as-needed or referral basis. Counselors also provide comprehensive assessment and use practices like Screening, Brief Intervention, Referral to Treatment (SBIRT), motivational interviewing, and stage of changes to assess for services needed and can refer the student to outpatient or inpatient treatment if appropriate.

The Substance Use and Mental Health Leadership Council of RI (SUMHLC)

is a nonprofit membership organization funded through the treatment set-aside within the Substance Abuse Block Grant. SUMHLC represents public and private alcohol and drug treatment, behavioral health, and prevention providers while promoting a collaborative, coordinated system of comprehensive community-based mental health, substance abuse

prevention and treatment services which include but are not limited to treatment and recovery-focused training opportunities.

The Rhode Island Certification Board (RICB)
is dedicated to consumer protection through offering competency-based credentials to behavioral health, community health and prevention professionals and maintenance of ethical standards and procedures for practice. RICB offers examinations and certification in the following behavioral health professional categories: Counselor, Prevention Specialists and Supervisors, Clinical Supervisor, Community Health Worker, Peer Recovery Specialist and Student Assistance Counselor. The RI Certification Board has been a participating member in the International Certification & Reciprocity Consortium (IC&RC) since 1988. (IC&RC sets international standards for professional competencies in behavioral health and develops and maintains written examinations for each reciprocal credential offered.)

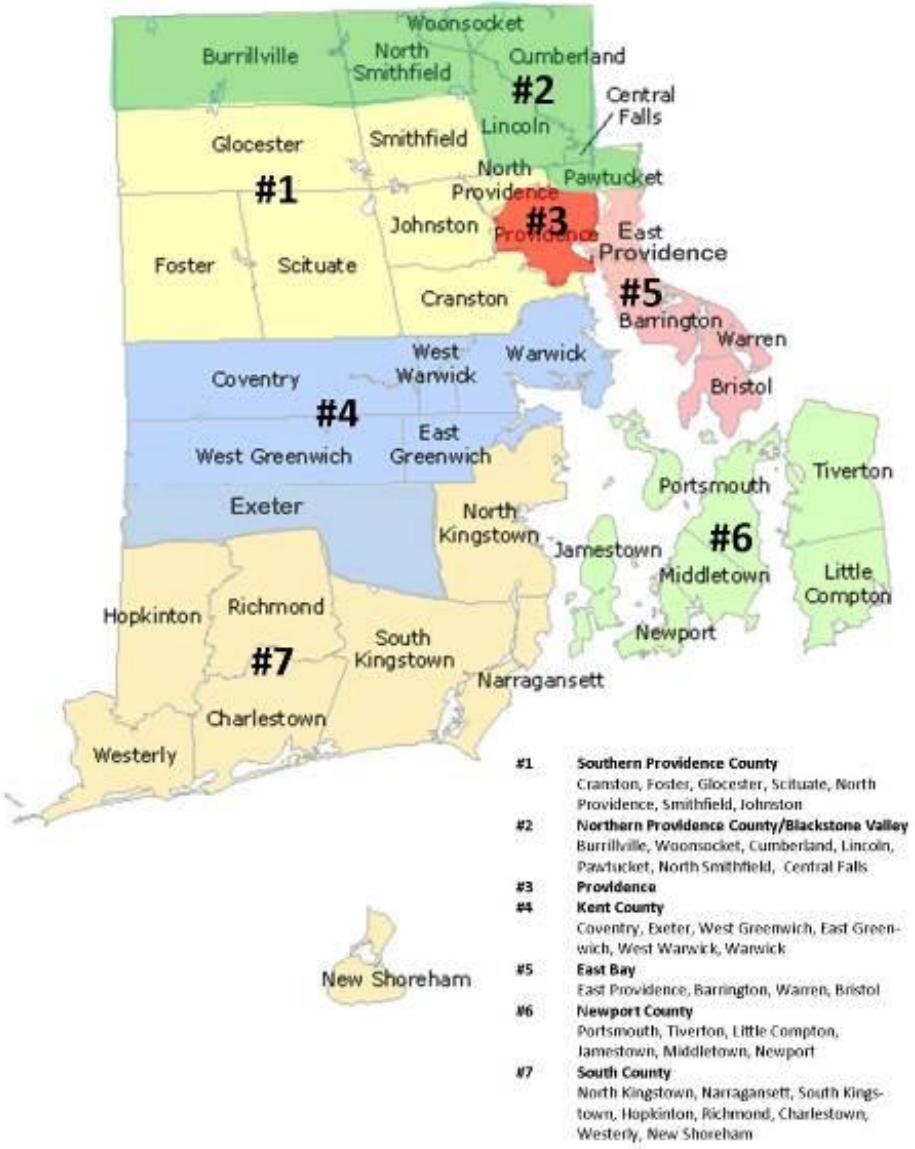
For more information, email info@ricertboard.org.

Regional Prevention Task Forces and Municipal Task Forces

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-four **Municipal Task Forces**, covering almost 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.

In 2017, BHDDH put in place seven **Regional Task Forces** to oversee the planning and delivery of substance use prevention and behavioral health promotion activities within the municipalities that comprise the region. Each Regional Task Force must assess community substance use prevention needs, resources, and behavioral health promotion, and develop a capacity building plan to address gaps in resources or community readiness, as well as produce a strategic plan, incorporating evidence-based and best practice interventions. Each Task Force includes city and town representation, which ensures that individual communities' municipal coalitions will continue to play an active role in planning and service provision, as well as promoting behavioral health services. The Regional Task Forces provide administrative oversight, funding and other needed resources to support the smaller municipal coalition contributions as part of a larger regional prevention plan.

1. **Southern Providence County** (*Cranston, Foster, Glocester, Scituate, North Providence, Smithfield, Johnston*)
2. **Northern Providence County/Blackstone Valley** (*Burrillville, Woonsocket, Cumberland, Lincoln, Pawtucket, North Smithfield, Central Falls*)
3. **Providence**
4. **Kent County** (*Coventry, Exeter, West Greenwich, East Greenwich, West Warwick, Warwick)*
5. **East Bay** *(East Providence, Barrington, Warren, Bristol)*
6. **Newport County** (*Portsmouth, Tiverton, Little Compton, Jamestown, Middletown, Newport)*
7. **South County** (*North Kingstown, Narragansett, South Kingstown, Hopkinton, Richmond, Charlestown, Westerly, New Shoreham*)



Other Rhode Island Organizations

These are state offices and programs, and local groups and providers whose work encompasses substance use issues and with whom coalitions may collaborate on prevention initiatives.

The RI Department of Health (DOH)
is the state agency responsible for preventing disease and protecting and promoting the health and safety of the people of Rhode Island. Many of the Department's health and wellness programs, as well as the network of health centers and health care providers licensed by DOH, include tobacco control, substance use prevention, treatment initiatives and services.

The RI Department of Transportation, Office on Highway Safety
among its many initiatives, works to prevent drunk and drugged driving and enforce laws against operating under the influence.

The RI Department of Human Services, Division of Elderly Affairs
seeks to "preserve the independence, dignity, and capacity for choice for seniors, adults with disabilities, families and caregivers." As part of its efforts to support the health and wellness of elders, the Division promotes safe use of prescription drugs and prevention of substance abuse.

The RI Office of the Attorney General
is the top legal official in Rhode Island. The Attorney General fights to enhance the economic security of the State, protect the public safety of RI communities and restore public trust in government by fighting corruption. The Attorney General represents all agencies, departments and commissions in litigation and initiates legal action where necessary to protect the interests of Rhode Island citizens. The Attorney General's Office works to address underage sales of tobacco and alcohol, as well as legal issues related to other illicit substances.

The Overdose Prevention and Intervention Task Force
was created by executive order to advise the Governor. Its members are appointed by the Governor and include stakeholders with expertise in public health, public safety, healthcare delivery, health insurance, prevention, treatment, and recovery support services, public health licensing, public health research, health disparities, business and other relevant areas. The Directors of DOH and BHDDH serve as co-chairs. The main charge of the Task Force is to develop action plans and recommendations to address the addiction and overdose crisis in Rhode Island, and to monitor progress in implementing them.

Health Equity Zones (HEZ)
are part of an initiative of the RI DOH. A HEZ is an economically disadvantaged, geographically defined area with documented health risks. A group of volunteer

stakeholders, organized as a "HEZ collaborative," works to achieve health equity for the residents of the HEZ by eliminating health disparities, and using place-based (where you live) strategies to promote healthy communities.[i]

Tobacco Free RI
is a network that brings together the people and organizations working on tobacco control in RI. TFRI facilitates communication and share information, resources and strategies for policy change. TFRI also provides advice and technical assistance to its network partners on best and promising policy practices, and convenes meetings and trainings so that network members can collaborate effectively and develop common policy change strategies.

Local behavioral healthcare providers: Visit the BHDDH website for listings of licensed mental health and substance use treatment providers in Rhode Island.

Rhode Island Strategic Plan for Substance Abuse Prevention

State, regional and community-level prevention initiatives should align with the state's Strategic Plan, developed by BHDDH. The Strategic Plan for Substance Abuse Prevention 2016-2019 aims to provide a roadmap for:

- Increasing the capacity of the state's prevention workforce
- Supporting key stakeholders, prevention providers and policy makers to understand, promote and work towards preventing and reducing substance use among youth and young people
- Creating an integrated prevention service delivery system which incorporates a broader behavioral health approach

The Strategic Plan describes *state substance abuse prevention priorities* based on the RI state epidemiological profile, and aligned with SAMHSA strategic initiatives for the nation. These priorities are the targets and focus for primary prevention strategies implemented at the community level and include:

- *Priority consequences of substance misuse*, including illicit drug dependence or abuse, alcohol dependence or abuse, drug overdose (especially opioids), and suicide attempts among adolescents.
- *Priority consumption patterns,* including marijuana use by adolescents ages 12-17, use of illicit drugs other than marijuana (ages 12-25), underage drinking (ages 12-20), and youth use of tobacco or tobacco related products especially use of electronic nicotine delivery systems (ENDS).

- *Priority risk factors,* including the low perception of risk or harm from substance use (especially substances listed under priority consumption patterns), ease of access (including perceived ease of access) to substances.

- *Priority protective factors,* including mental health resiliency.

In addition, the Strategic Plan outlines strategic goals and objectives for: 1) system-level development of the state's prevention infrastructure focusing on integration of substance use prevention and mental health promotion, 2) development and sustainability of the state's prevention workforce, and 3) reduction of priority risk factors.

The Strategic Plan for Substance Abuse Prevention 2016-2019 may be downloaded from the BHDDH website.

Funding Sources for Community Substance Abuse Prevention

Most funding for community substance abuse prevention comes from the federal government. The Substance Abuse and Mental Health Administration (SAMHSA) provides funding to the states through the following prevention grant programs supported by SAMHSA's Center for the Application of Prevention Technologies (CAPT):

Substance Abuse Prevention and Treatment Block Grant (SABG)
Since 1993, the SABG program has provided block grants to states, tribes, and jurisdictions to plan and implement activities to prevent and treat substance use disorders. These block grants serve as the primary source of substance misuse and treatment funding in most states. Specifically, they account for approximately one-third of total state substance use agency funding and one-fourth of total state substance use prevention and public health funding. The grants are awarded to the agency responsible for preventing substance use disorders within the state, who then distributes some of the funding to local programs.

Partnerships for Success (PFS)
PFS grant programs aim to reduce substance misuse and strengthen prevention capacity at the state, tribe, and jurisdiction levels. They do this by helping grantees leverage and realign statewide funding streams for prevention. PFS is based on the premise that changes at the community level will lead to measurable changes at the state level. Through collaboration, states and their PFS-funded communities of high need can overcome challenges associated with substance misuse. The grants are awarded to the agency responsible for preventing substance use disorders within the state, who then distributes the funding to local programs.

The Drug Free Communities (DFC) Program was created by the Drug-Free Communities Act of 1997, and is administered by SAMHSA and the Executive Office of the President. By statute the program has two goals: 1) Establish and strengthen collaboration among communities, public and private non-profit agencies; as well as federal, state, local, and tribal governments to support the efforts of community coalitions working to prevent and reduce substance use among youth, and 2)Reduce substance use among youth and, over time, reduce substance abuse among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse. Local communities can apply directly to SAMHSA for DFC funding.

Other funding sources: Cities and towns may also apply to local or national foundations for substance use prevention funding. From time to time BHDDH or the RI DOH may offer mini-grants for which community-based programs may apply.

EXPECTATIONS/SCOPE OF WORK OF REGIONAL TASK FORCES

Research has shown that community coalitions, such as Rhode Island's Regional Prevention Task Forces and Municipal Task Forces, can be effective agents for public health promotion and can reduce negative outcomes associated with behavioral health problems when community stakeholders are actively engaged and culturally-appropriate, evidence-based practices are implemented.

This section provides an overview of the mission, roles and responsibilities of the Regional Prevention Task Forces, and describes membership and governance of the Task Forces, including collaboration with Municipal Task Forces. Links are provided to resources and tools that can assist Regional Task Forces in carrying out their designated responsibilities and activities.

Mission and Objectives

In service to Rhode Island's broad goal to prevent and reduce substance abuse among youth and young adults, the mission of the Regional Prevention Task Forces is to enhance the ability of local municipal coalitions to implement evidence-based practices designed to engage communities and attain population level changes in consumption patterns.

The Regional Task Forces are tasked with providing regionalized coordination, which will increase the capacity of the Municipal prevention coalitions, while promoting efficiencies in process and improved outcomes. Additionally, Regional Task Forces are intended to promote a lifespan approach, encourage collaboration across the continuum of care among multiple stakeholder groups concerned with behavioral health and to leverage federal and private dollars to address local behavioral health priorities. More specifically, the Regional Task Forces have three priority objectives:

1. To increase the use of evidence-based policies, practices and programs by municipal substance abuse prevention coalitions, as well as among various sectors and community stakeholders (e.g., schools, law enforcement, prescribers of opioid medications), based on the findings of the municipal needs assessments.

2. Implement environmental change strategies to raise awareness of potential for harm from substance use, and reduce youth access to harmful products such as tobacco and marijuana.

3. Use media and communication strategies to promote positive behavioral health, increase the perception of risk or harm from substance use, and correct misperceptions of normative behavior among youth and young adults (e.g., "everyone drinks alcohol").

Efforts to include mental health promotion in the work of Municipal Task Forces, and primary prevention efforts with positive outcomes related to prevention of suicide across the lifespan, should also be foci.

Regional Prevention Task Force Membership

While the Regional Prevention Task Force is responsible for overseeing the planning and delivery of prevention activities within the municipalities that comprise the region, the municipal substance abuse prevention coalitions retain their individual identities and continue to provide prevention services to their communities.

To ensure that individual communities continue to play an active role in planning and service provision, as well as promoting behavioral health services, each Regional Prevention Task Force must include city and town representation from all municipalities within the region. Municipal representation should be formalized with a signed Memorandum of Understanding (MOU). *Sample provided in Appendix 4.*

In addition, the Regional Prevention Task Forces should encourage collaboration across the continuum of care among multiple stakeholder groups concerned with behavioral health. The Task Forces must engage representatives from the following six sectors:

- Business (including pharmacies, retail stores, and local area employers)
- Education (including schools, colleges and universities, local education agency)
- Safety (including police and fire departments, local EMS)
- Medical/health (including community health centers and community mental health centers, hospitals, health care provider representatives)
- Government (including municipal government, department of health, parks and recreation)
- Community/family supports (community centers, Y, youth serving organizations)

Core Responsibilities of Regional Prevention Task Forces

The Regional Prevention Task Forces' overarching goal is to identify and leverage resources to address behavioral health needs within Rhode Island cities and towns by helping communities to provide comprehensive substance use prevention and behavioral health promotion interventions including promoting wellness. Within this broad scope of work, the Task Forces have prescribed core responsibilities related to:

- Regional and local needs assessments
- Regional strategic plan and local work plans
- Implementation and monitoring of planned activities
- Prevention workforce development

Regional and Local Needs Assessments

Rhode Island Regional Prevention Task Forces are required to conduct an assessment of population needs in their geographic area related to the substance use and behavioral health issues identified by the state as priority problems: alcohol use, marijuana use, opioid use, non-medical prescription drug use, depression and suicide. The needs assessment is designed to increase understanding of who in the community is affected by each problem, how the priority problem is manifesting in the community, and what conditions within the community are contributing to the problem (risk and protective factors). The needs assessment process involves the collection and analysis of both quantitative and qualitative data, as shown in the figure below. Quantitative data is numerical or statistical data that shows how often an event/behavior occurs or to what degree it exists. Qualitative data helps explain why people behave or feel the way they do.

A good needs assessment is a basic first step that provides vital information to help set prevention priorities, inform the Regional Strategic Plan and municipal work plans, and mobilize the local community. Needs assessment data can help Regional Task Forces to "make the case" for specific actions to providers, educators, municipal agencies, businesses and the public.

A comprehensive and practical guide to conducting needs assessments in Rhode Island communities is available here to all Regional Task Forces and Municipal Task Forces. *Rhode Island Regional Prevention Task Force Coalitions: A Guide to the Community Needs Assessment* provides checklists of archival and survey variables and data sources for each

priority problem, as well as survey tools (ready-to-use questionnaires) that can be disseminated in the community. The guide also offers recommendations for collecting qualitative data through focus groups and interviews, and provides interview and focus group questions for each priority problem area. Finally, the guide presents methods, tools and templates for using needs assessment data and findings to identify priorities for regional and local strategic plans. State and local data sources are available here and in Appendix 3.

Regional Strategic Plan and Local Work Plans

Each Regional Prevention Task Force is charged with creating a Regional Strategic Plan addressing priority problems identified in the State's Strategic Plan for Substance Abuse Prevention. The Regional Strategic Plan must aim to reduce the impact of at least one of the following state identified priority areas:

- Prevent and/or reduce consequences of underage drinking, ages 12-17 and adult problem drinking, ages 18-25.
- Prevent and/or reduce consequences of marijuana use by adolescents ages 12-17.
- Prevent and/or reduce consequences of illicit drug use, other than marijuana, ages 12-25.
- Prevent or reduce consequences of youth use of tobacco or tobacco-related products especially use of electronic nicotine delivery systems (ENDS).

Selection of which state priority or priorities will be targeted in the Regional Strategic Plan will be driven by examination of local and regional data and needs assessments. The Task Force plan will draw information from a set of municipal needs and resource assessments to identify regional prevention priorities aligned with the State's priority areas above.

The Regional Strategic Plan will describe the best practices and evidence-based interventions that may be employed at the municipal level to address the identified regional as well as local priority problems. The Plan will specify how the region will operationalize each of the following strategies for preventing substance abuse and promoting behavioral health:

- Information dissemination: e.g. health fairs, media campaigns, social marketing, resource directories, Public Service Announcements;

- Education: two-way communication between educator/facilitator and participant, e.g. classroom, small group sessions, parenting/family classes, education programs for youth;
- Alternatives: constructive and healthy activities that exclude alcohol, tobacco, and other drug use: e.g. drug-free social and recreational activities, community drop-in centers, mentoring programs, community service activities;

Key Components of a Strategic Plan

- Data (summary of needs assessment)
- Goals and Objectives
- Strategies (evidence-based)
- Activities and Products
- Division of Work (who does what)
- Timeline
- Funding Allocations
- Measures (process and outcome)

- Environmental strategies: e.g. school drug policies, product pricing, local regulations, technical assistance to maximize local enforcement;
- Community-based processes: approach that enhances the community's ability to more effectively provide substance abuse prevention services: e.g. systemic planning, community team building, multi-agency coordination/collaboration, community and volunteer training, assessing service and funding.

Finally, Regional Strategic Plans must include provisions for implementing the Rhode Island Student Survey (RISS).

Municipal Work Plans

The Regional Prevention Task Force must also assist each member Municipal Task Force with the development of a municipal multi-year work plan to address both their local and selected regional needs and priorities. Each municipality will have the ability to select from among the evidence based practices identified in the Regional Prevention Plan those that are congruent with the culture and context of their community. These municipal work plans must specify:

- The specific evidence-based practices and prevention interventions that will be employed locally
- How the local community will conduct and analyze a needs assessment and procedures for data collection, analysis and data management

- Strategies intended to reduce youth access to tobacco products (Synar Amendment Compliance)

Mosaix IMPACT Description for Regional and Municipal Task Forces

Purpose:

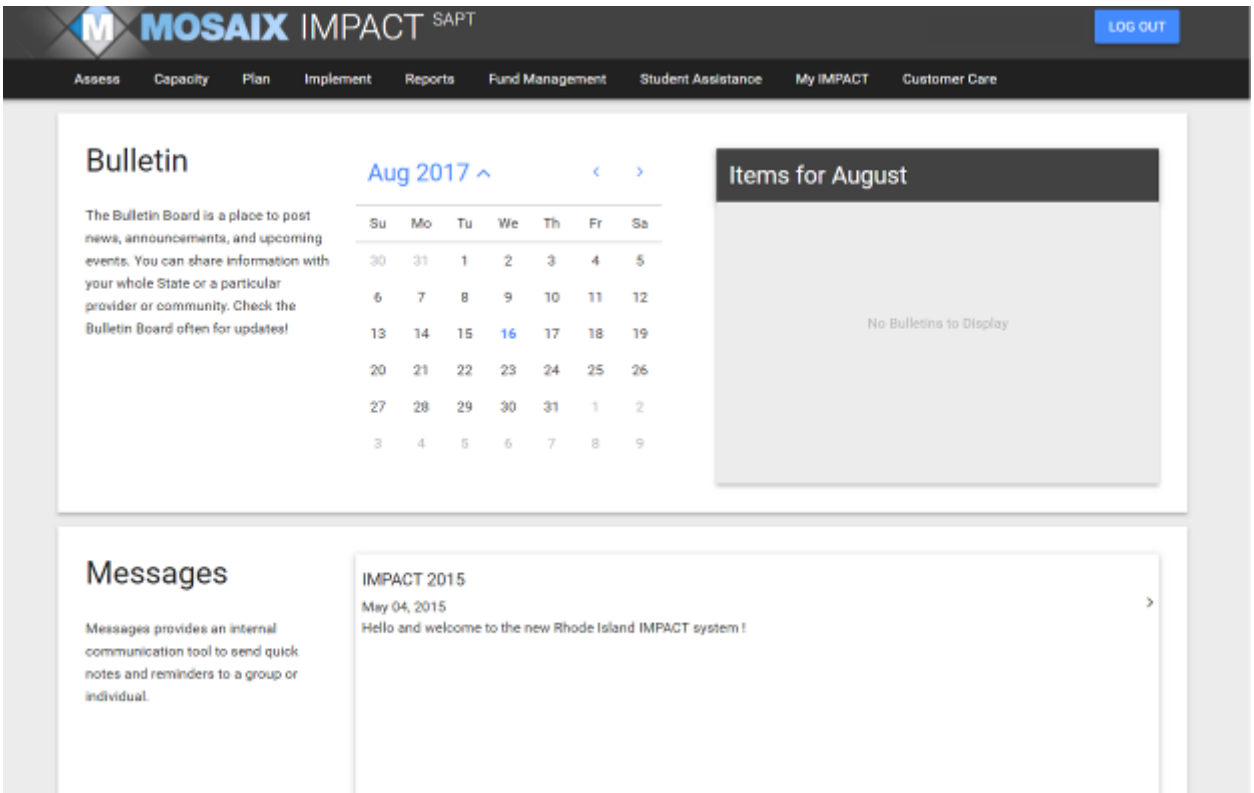
The Mosaix IMPACT System is a prevention data collection system for Substance Abuse Prevention and Treatment (SAPT) Block Grant recipients and other SAMHSA and other federal grant providers such as: Student Assistance Services, RI Prevention Resource Center and Regional and Municipal Prevention Task Forces.

Mosaix IMPACT also provides reports in a format that fulfills BHDDH, SAPT Block Grant and other discretionary grants. RPTF contract requires data to be entered into the Mosaix IMPACT by the 15th of the following month.

See Appendix 4 for a sample of a regional strategic plan.

Sample Mosaix IMPACT Modules

- Logic Models
- Event details
- Objectives
- Needs Assessments
- Activities



Prevention Workforce Development

In addition to raising public awareness and mobilizing communities around substance use prevention and promotion of mental health and wellness, regional task forces have an important role to play in building the capacity of the prevention workforce in Rhode Island. In addition to providing a forum for knowledge exchange and collaboration among members, task forces and coalitions should facilitate and publicize opportunities for task force members and others in the community to build their behavioral health knowledge and skills.

Task force and coalition coordinators can support the development of the prevention workforce in Rhode Island by:

1. Periodically (for example, quarterly) scheduling mini-trainings on current and emerging behavioral health issues and topics as part of task force or coalition meetings (full meetings or committee meetings).

2. Making task force and coalition members aware of the broad array of training opportunities (many of which contribute to certification) available through Rhode Island, regional and federal organizations. *See side bar for a starter list.*

3. Promoting behavioral health and prevention training opportunities more broadly to community-based agencies and organizations.

Task Force Governance and Operations

The Task Force needs to put in place rules, structures and procedures to keep it operating smoothly, effectively and fairly. This includes establishing bylaws, developing procedures for meeting planning and logistics, electing officers, instituting agreed on

Training Resources for RI Prevention Task Force Coordinators and coalition members

The following entities offer in-person training, webinars, online learning, toolkits and other resources for prevention specialists, health care and behavioral health providers, community coalition members and other interested parties.

- Rhode Island Prevention Resource Center
- Substance Use and Mental Health Leadership Council (SUMHLC) of RI
- SAMHSA, CAPT: Center for the Application of Prevention Technologies https://www.samhsa.gov/capt/CAPT/
- New England Institute of Addiction Studies
- New England Addiction Technology Transfer Center (ATTC-NE)

methods for decision-making, establishing a committee structure if desired, and clarifying and communicating expectations of members.

Meetings: Task forces are required to meet at least monthly. Meeting logistics, announcements, and materials are handled by the task force coordinator. The agenda for each meeting is set by task force leadership, supported by the coordinator, and in accordance with procedures, stated in the bylaws.

Leadership and Committees: Every task force should have a leader, usually called the Chair. This responsibility may be shared by two or more persons, called Co-Chairs, or there may be a Chair and Vice Chair(s). The bylaws will specify how the Chair(s) is selected, most commonly via election by task force members. Some task forces may establish committees for more in-depth and focused attention to particular initiatives or to deal with emerging issues, for example committee on developing social marketing campaigns.

Task Force Bylaws

Each Task Force should have written rules, called bylaws, which explain how the Task Force operates. Bylaws should be clear and specific, and should include at least the following:

- Mission of the Task Force
- Member terms and how members are selected
- Duties of members
- Officers and their duties
- Duties of staff (coordinators)
- How meetings are announced and run
- How decisions are made (voting or consensus)
- What committees the Task Force has and how they operate
- Conflict of interest policy
- Code of conduct for members
- How the bylaws can be amended

See Appendix 4 for samples of community and regional bylaws.

Facilitating Effective Collaboration within the Task Force

The diversity and broad representativeness of task force membership is a great asset and strength, permitting multiple perspectives and broad-based buy-in and commitment to regional and local prevention initiatives. At the same time, this multiplicity of perspectives

and agendas can lead to disagreements or conflicts and make it difficult to manage discussion during task force meetings.

Having a clear agenda and meeting procedures in place can help greatly, but much of the burden for facilitating a productive meeting falls upon the Chair(s).

To run an effective meeting, the Chair(s) should:

- Demonstrate understanding of Robert's Rules of Order and Task Force bylaws
- State the purpose and goals of the meeting as defined by the agenda
- Invite participation by all members of the Task Force throughout the meeting
- Listen to Task Force members and treats all members with respect
- Define steps to a rational problem solving sequence for arriving at decisions, recommendations or actions
- Use humor and positive affect to defuse heated arguments and encourages civil disagreement
- Stress the need for consensus and compromise
- Begin and end the meeting on time.

Task Force Staffing

Given the ambitious agenda of the prevention task forces, they must have dedicated staffing, paid for by the grant, to direct, coordinate and manage their broad scope of work. BHDDH has specified the following duties for these Coordinator positions.

Roles and Responsibilities of Regional and Municipal Prevention Coordinators

Regional Prevention Coordinator

- Identify shared needs and resources within the region
- Advocate for needed resources within the region including human, technical and financial resources based on municipal/community needs and resource assessment
- Leverage needed resources within the region and within individual municipalities including human, technical and financial resources
- Assist Municipal Task Forces in creating municipal (local) work plans based on a comprehensive municipal needs and resources assessment

- Assist Municipal Task Forces in creating a multi-year funds development and funds diversification plan

- Enter data related to progress in the implementation of the regional strategic plan and the annual municipal work plans into the Mosaix IMPACT prevention platform

- Report and monitor progress in achieving goals and objectives related to the regional prevention plan and individual municipal prevention plans

- Oversee activities of all the community prevention coalitions within their region to ensure that there are coordination efforts, activities and available resources

- Convene the members of the region, including all municipal prevention coalition coordinators, as a regional prevention coalition to meet on a monthly basis for the duration of the award

- Provide documentation and reports, with frequency and in the format to be determined by BHDDH, detailing funded activities within the region including those being implemented at the municipal level

- Participate in a statewide evaluation design to measure impact on substance related problems

- Implement municipal compliance with federal Synar Regulation requirements including monitoring the implementation of eligible prevention strategies and activities

The Regional Prevention Coordinator must at least be a Certified Prevention Specialist (CPS) or be in the process of obtaining this credential/certification.

Municipal Task Force Coordinator

- Identify municipal stakeholders across the six core sectors, behavioral health foci and continuum of care
    - Business
    - Education
    - Medical/health
    - Government
    - Community/family supports

- Develop a municipal recruitment and retention plan for the six core sectors

- Recruit and engage multiple municipal representatives of the six core sectors

- Facilitate at least 10 meetings a year of the Municipal Task Force

- Assess municipal needs and resources using a standard assessment protocol provided by the Regional Prevention Coalition

- Develop a multi-year municipal prevention plan in collaboration with the Regional Prevention Coordinator

- Develop annual work plans detailing the approach described in the municipal prevention plan for the period of the award

- Identify at least one partner among the six core sectors with the requisite readiness and capacity to implement a pilot, evidence-based practice each year for years 2-5 and assist them with developing a plan to sustain or expand the pilot if the initial implementation is successful

- Implement a multi-year funds development plan for the Municipal Task Force as described above

RI EXAMPLES OF IOM'S CONTINUUM OF CARE FOR PREVENTION

Below are examples of how regional and community coalitions are implementing the Institute of Medicine's Continuum of Care, referenced on page 8.

Universal

These are prevention interventions that focus on general public or a population that are not identified based on risk factors. Samples include:

Policies: Tobacco-free Parks

Mayor's Substance Abuse Prevention Council, Providence:

The Mayor's Substance Abuse Prevention Council worked with local decision makers and community partners to educate and promote the benefits for tobacco-free public places. Effective March 11, 2015, the sale or use of all tobacco and nicotine products including cigarettes, cigars, hookah, chewing tobacco, and electronic cigarettes in all city owned parks, playgrounds, and recreation facilities is prohibited.

The Council also supported community celebrations to promote the policy and public awareness campaigns to promote the Tobacco-Free Parks policy.

Social Marketing: "Cost is Too High"

The BAY Team, Barrington

The BAY Team has worked collectively with the community to educate and inform parents and students about the dangers of substance abuse to their overall health and safety. A

component of social marketing strategies is to educate and influence voluntary behaviors through a variety of messages regarding the effects of marijuana and youth.

The media message is also connected to a guide that provides parents with updated information about the effects of marijuana on young people. It also includes the latest information about e-cigarettes. It is our hope that you will find this guide "The Cost is Too High" to be a useful resource when talking with your children about the dangers of substance use.

Selective

These are prevention initiatives focusing on individuals or sub-groups whose risk is higher due to external influences.

RI Student Assistance Program: Project Success

Student Assistance Program is based on the National Center for Substance Abuse Prevention (CSAP) model program Project Success. Project Success is located in schools, where adolescents have easy access to highly trained counselors and where alcohol and other drug use-related risk factors, such as drinking at an early age, poor academic performance, deviant school behavior and poor parent-child relationships are more likely to be detected than at home. Master's-level counselors provide a wide range of prevention and early intervention services. Parents, school administrators, teachers and others in the community find Project Success a highly effective model for addressing alcohol, drug and other problems which negatively impact academic performance and attendance.

The goals of Project Success are to enhance the resiliency of adolescents whose parents are substance abusers; delay adolescents' initial use of alcohol, tobacco and other drugs; and

decrease adolescents' use of alcohol, tobacco and other drugs. A valuable characteristic of Project Success is its ability to identify and help youth, especially those at high risk, before the onset of alcohol and other drug problems. This early detection and intervention has proven effective in delaying the initiation and use of alcohol and other drugs, and reducing the resultant school/life problems.

The Rhode Island Student Assistance Services is a statewide school-based alcohol, tobacco and other drug abuse prevention/early intervention program operating since 1987. RISAS is available in 22 middle/junior high schools and 25 high schools, representing 24 districts.

Indicated

Prevention initiatives focusing on individuals who exhibit high risk behaviors but have not met a diagnostic level at the time of the intervention

Practical Academic Support Seminar (PASS) Program

Citizen and Students Together (CAST), Foster/Glocester:

Practical Academic Support Seminar (PASS) is a school-based indicated prevention program for high school students with poor school achievement and potential for dropping out. The program goals are to increase school performance, reduce drug use, and learn skills to manage mood and emotions. It is geared toward 9-12 graders who are identified by Guidance Counselor's as engaging in a variety of high-risk behaviors that result in additional risk of academic failure. The setting of the program is in a conference room-type setting known as the Student Success Center within the high school. Students are provided with a workbook where they will rate their own successes, e.g. class attendance, organization, goal completion, self-management, including coping with emotions, etc. Students are recommended by parents, faculty, or administration for assessment to determine a program match. Students attend a PASS Class daily and are monitored by Guidance throughout the school year until significant academic improvement is evident. PASS is a collaborative project between Guidance staff and Faculty. Students who may be identified as abusing substances may also be referred to the Student Assistance Counselor for additional support.

It is expected that the success academically will translate to enhanced life skills, such as goal setting, task mastery, self-advocacy, and organization. Decision making and communication skills are taught to enhance self- esteem, self-confidence, and to enhance Developmental Assets. The more Developmental Assets students have, the less their risk for substance abuse and other risk behaviors.

APPENDICES

Appendix 1: COMMON ACRONYMS

- National
- Rhode Island-specific

AMA	American Medical Association
AOD	Alcohol and other drugs
APA	American Psychological Association
APHA	American Public Health Association
ATF	Bureau of Alcohol, Tobacco, Firearms and Explosives
ATOD	Alcohol, tobacco and other drugs
BAC	Blood alcohol content
CADCA	Community Anti-Drug Coalitions of America
CAPT	Center for the Application of Prevention Technologies
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CMHS	Center for Mental Health Services
CPS	Certified Prevention Specialist
CPSS	Certified Prevention Specialist Supervisor
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
DEA	U.S. Drug Enforcement Administration
DFC	Drug Free Communities [Grantee or Mentee]
DFSCA	Drug Free Schools and Communities Act
DUI	Driving under the influence
DWI	Driving While Intoxicated
EAP	Employee Assistance Programs
ED	U.S. Department of Education
FASD	Fetal Alcohol Spectrum Disorders
FBI	Federal Bureau of Investigations
FDA	Food and Drug Administration
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
IC&RC	International Certification and Reciprocity Consortium
IOM	Institute of Medicine
IRB	Institutional Review Board
MADD	Mothers Against Drunk Driving
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NIAA	National Institute on Drug Abuse
NOMs	National Outcome Measures
NPN	National Prevention Network
NREPP	SAMHSA's National Registry of Evidence-Based Programs and Practices
NSDUH	National Survey on Drug use and Health
N-SSATS	National Survey on Substance Abuse Treatment Services
OJJDP	Office of Juvenile Justice and Delinquency Prevention
ONDCP	Office of National Drug Control Policy
RADAR	Regional Alcohol and Drug Awareness Resource Network
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment Block Grant
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDFSCA	Safe and Drug Free Schools and Communities Act
SIG	State Incentive Grant[ee]
SPF	Strategic Prevention Framework
SSA	Single State Agency

Rhode Island-specific

BHDDH	Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
CPRC	Cancer Prevention Research Center
CRST	Community Research and Services Team
DATA	Drug and Alcohol Treatment Association
DBH	Division of Behavioral Healthcare
DCYF	RI Department of Children, Youth and Families
GCBH	RI Governor's Council on Behavioral Health
PAC	Prevention Advisory Committee
RICARES	RI Community of Addictions Recovery Efforts
RICCMHO	RI Council of Community Mental Health Organizations
RIDE	Rhode Island Department of Education
RIDOH	RI Department of Health
RIPRC	RI Prevention Resource Center
RISAPA	RI Substance Abuse Prevention Act
RISAS	RI Student Assistance Services
RISS	Rhode Island Student Survey
RPC	Regional Prevention Coordinator
RSAPC	Regional Substance Abuse Prevention Coalition/Task Force
SEOW	State Epidemiological Outcomes Workgroup
SUMHLC	Substance Use Mental Health Leadership Council

Appendix 2: GLOSSARY

A

Activities: Efforts to be conducted to achieved identified objectives.

Adaptation: Modifications made to a chosen intervention; changes in audience, setting, and/or intensity of program delivery. Research indicates that adaptations are more effective when underlying program theory is understood; core program components have been identified; and both the community and needs of a population of interest have been carefully defined.

Addiction/stages of addiction: Compulsive physiological need for and use of a habit-forming substance (as marijuana, nicotine or alcohol) characterized by tolerance and by well-defined physiological symptoms upon withdrawal.

Assessment (as a step in SPF): A process of gathering, analyzing and reporting information, usually data, about your community. A community assessment should include geographic and demographic information, as well as a collective review of needs and resources within a community that indicates what the current problems or issues are that could be addressed by a coalition.

B

Baseline: The level of behavior that is recorded before an intervention is provided or services are delivered.

Behavioral health: A state of mental/emotional being and/or choices and actions that affect wellness. The term *behavioral health* can also be used to describe the service systems surrounding the promotion of mental health, the prevention and treatment of mental and substance use disorders, and recovery support.

C

Capacity (as a step in SPF): The various types and levels of resources that an organization or collaborative has at its disposal to meet the implementation demands of specific interventions. Capacity includes both the resources a community has to address its problems (e.g., programs, organizations, people, money, expertise) and how ready the community is to take action to address its problems.

Capacity building: Increasing the ability and skills of individuals, groups and organizations to plan, undertake and manage initiatives. The approach also enhances the capacity of the individuals, groups and organizations to deal with future issues or problems. Building capacity involves increasing the resources and improving the community's readiness to do prevention.

CNS depressants: A class of drugs (also called sedatives and tranquilizers) that slow CNS function; some are used to treat anxiety and sleep disorders (includes barbiturates and benzodiazepines).

Coalition: A formal arrangement for cooperation and collaboration between groups or sectors of a community, in which each group retains its identity but all agree to work together toward a common goal of building a safe, healthy and drug-free community.

Community: People with a common interest of experience living in a defined area. For example, a neighborhood, school district, town, part of a county, county, congressional district or regional area.

Community Readiness: The degree of support for or resistance to identifying substance use and abuse as significant social problems in a community. Stages of community readiness for prevention provide an appropriate framework for understanding prevention readiness at the community and state levels.

Confidentiality: Keeping information given by or about an individual in the course of professional relationship secure and secret from others.

Co-occurring disorder: Having one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs.

Cultural competence: Cultural competence, at the individual, organizational, and systems levels, involves being respectful and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse people and groups.

Cultural diversity: Differences in race, ethnicity, language, nationality or religion among various groups within a community. A community is said to be culturally diverse if its residents include members of different groups.

Culture: The shared values, traditions, norms, customs, arts, history, folklore and institutions of a group of people that are unified by race, ethnicity, language, nationality or religion. C*ulture* refers to "integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups."

D

Depressants: Drugs that relieve anxiety and promote sleep. Depressants include barbiturates, benzodiazepines, and alcohol.

Developmental Approach/Perspective: A developmental approach to prevention suggests that risk and protective factors and their potential consequences and benefits are organized according to defined developmental periods. This enables practitioners to match their prevention efforts to the developmental needs and competencies of their audience. It also helps planners align prevention efforts with key periods in peoples' development, when they are most likely to produce the desired, long-term effects.

E

Environmental strategies: Prevention efforts aimed at changing or influencing community conditions, standards, institutions, structures, systems and policies.

Epidemiological data: Measures of the frequency, distribution and determinants of diseases in a population, rather than in an individual.

Epidemiology: The study of factors that influence health and illness in populations. Epidemiologists study the distribution and determinants of the health and wellness of populations.

Ethics: The rules and standards governing professional conduct. Core ethical principles in prevention include: nondiscrimination, competence, integrity, nature of services, confidentiality, and ethical obligations to community and society.

Evaluation (as a step in SPF): Evaluation is the systematic collection and analysis of information about an intervention to improve its effectiveness and make decisions. A process that helps prevention practitioners to discover the strengths and weaknesses of their activities

Evidence-based prevention interventions: An Evidence-based Intervention is a prevention service (program, policy, or practice) that has been proven to positively change the problem being targeted. In general, there needs to be evidence that the intervention has been effective at achieving outcomes through some form of evaluation.

Expected outcomes: The intended or anticipated results of carrying out program activities. There may be short-term, intermediate and long-term outcomes.

F

Fidelity: When replicating a program model or strategy, fidelity is to implement the model or strategy with the same specifications as the original program. Fidelity can be balanced with adaptation to meet local needs.

Focus group: Structured interview with small groups of like individuals using standardized questions, follow up questions, and exploration of other topics that arise to better understand participants.

G

Goal statement: A description of the specific ends you wish to achieve through the implementation of a model, plan, or program.

H

Hallucinogens: A diverse group of drugs that alter perceptions, thoughts, and feelings. Hallucinogenic drugs include LSD, mescaline, PCP, and psilocybin (magic mushrooms).

Health disparities: A “health disparity” is a difference in health that is closely linked with social, economic, and/or environmental disadvantages. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

I

Impact evaluation: Evaluation that examines the extent of the broad, ultimate effects of a project, such as decrease in youth substance use in a community.

Implementation: Implementation involves mobilizing support for your efforts, selecting and carrying out evidence-based programs, policies, and practices, and monitor implementation to make mid-course corrections as necessary.

Indicated intervention: Indicated prevention interventions focus on higher risk individual identified as having signs and/or symptoms or behavior foreshadowing a mental, emotional, and/or substance use disorder.

Informed consent: The process of obtaining consent from participants that includes a full description and explanation of the activity presented in a way participants can understand and ensures that participants provide their consent willingly free from coercion or undue influence. *Active consent* requires a signature from all participants in a research project and/or their legal representatives. *Passive consent* requires a signature from only those individuals who do not agree to participate in the research activity and/or their legal representative.

Inhalant: Any drug administered by breathing in its vapors. Inhalants are commonly organic solvents, such as glue and paint thinner, or anesthetic gases, such as nitrous oxide.

J

K

Key informant: A person who has a specialized knowledge about a topic that you wish to understand and can convey that knowledge to you.

L

Lobbying: A type of advocacy that attempts to influence specific legislation.

Logic Model: The program logic model is defined as a picture of how your organization does its work – the theory and assumptions underlying the program. A program logic model links outcomes (both short- and long-term) with program activities/processes and the theoretical assumptions/principles of the program

M

Media Advocacy: The strategic use of media to advance a social and/or public policy initiative.

Media Literacy: The ability to access, analyze and produce information for specific outcomes and the ability to "read" and produce media messages.

Mental disorder: Mental disorders involve changes in thinking, mood, and/or behavior. These disorders can affect how a person relates to others and make choices.

Multisector: Several agencies, sectors, or types of institution working together.

Multistrategy: Utilizing more than one prevention strategy (information dissemination, skill building, environmental approaches, etc.) as part of a comprehensive prevention plan.

N

Norms: Pattern of behavior in a particular group, community or culture, accepted as normal and to which an individual is expected to conform.

O

Objective statement: Statements that describe the specific, measurable products and deliverables that the project will deliver.

Opioids (or opiates): Controlled substances most often prescribed for the management of pain. They are natural or synthetic chemicals similar to morphine that work by mimicking the actions of enkephalin and endorphin (endogenous opioids or pain-relieving chemicals produced in the body).

Outcome evaluation: Evaluation that describes the extent of the immediate effects of project components, including what changes occurred. Outcome evaluation documents whether the intervention made a difference, and if so, what changed.

P

Phases of the IOM continuum

> **Promotion:** Promotion involves interventions (e.g., programs, practices, or environmental strategies) that enable people "to increase control over, and to improve, their health." The focus of promotion is on well-being.
>
> **Prevention:** Prevention focuses on interventions that occur prior to the onset of a disorder and which are intended to prevent the occurrence of the disorder or reduce risk for the disorder. Prevention is also about striving to optimize well-being.
>
> **Treatment**: Interventions targeted to individuals who are identified as currently suffering from a diagnosable disorder that are intended to cure the disorder or reduce the symptoms of the disorder, including the prevention of disability, relapse, and/or comorbidity**.** Treatment interventions for substance use disorders include case identification and standard forms of treatment (e.g., detoxification, outpatient treatment, in-patient treatment, medication-assisted treatment).

Maintenance: Maintenance includes interventions that focus on compliance with long-term treatment to reduce relapse and recurrence and aftercare, including rehabilitation and recovery support.

Planning (as a step in SPF): Planning involves establishing criteria for prioritizing risk and protective factors, selecting prevention interventions, and developing a comprehensive, logical, and data-driven prevention plan.

Prevention: Interventions that occur prior to the onset of a disorder that are intended to prevent or reduce risk for the disorder.

Process evaluation: Evaluation that describes and documents what was done, how much, when, for whom and by whom during the course of the project. Process evaluation documents all aspects of the implementation of an intervention. It describes how the intervention was implemented.

Protective Factor: A characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a lower likelihood of problem outcomes.

Public health: What we, as a society, do collectively to assure the conditions for people to be healthy. The focus of public health is on the safety and well-being of entire populations by preventing disease rather than treating it.

Q

Qualitative data: Shows how often an event/ behavior occurs or to what degree it exists.

Quantitative data: Helps explains why people behave or feel the way they do.

R

Resilience: The ability to recover from or adapt to adverse events, life changes and life stressors.

Resiliency factors: Personal traits and social influences that allow children to survive and grow into healthy, productive adults in spite of having experienced traumatic events or high-risk environments.

Resources: The various types and levels of assets that a community has at its disposal to address identified substance abuse problems, including fiscal, human and organizational resources.

Risk factor: A characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes.

S

Selective intervention: A selective prevention intervention focus on individuals or sub-groups whose risk of developing mental health disorders and/or substance use disorders are significantly higher due to biological, psychological, and/or social risk factors.

Social Marketing: Social marketing is the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behaviors of target audiences in order to improve their personal welfare and that of their society.

Stakeholders: Stakeholders are the people and organizations in the community who have: a stake in prevention because they care about promoting health and well-being and have something to gain or lose by prevention or promotion efforts.

Stimulants: A class of drugs that elevates mood, increases feelings of well-being, and increases energy and alertness. Stimulants include cocaine, methamphetamine, and prescription drugs used to treat ADHD.

Strategic Prevention Framework: The Strategic Prevention Framework—or SPF—is a 5-step planning process used by SAMHSA to understand community needs and strengths, and to guide the selection, implementation, and evaluation of effective, developmentally and culturally appropriate, and sustainable prevention activities. The five steps are: Assessment, Capacity, Planning, Implementation, and Evaluation. Sustainability and Cultural Competence are included in all steps of the SPF.

Substance use disorder: Substance Use Disorder refers to the overuse of, or dependence on, a drug (legal or illegal) leading to effects that are detrimental to the person's physical and mental health, and cause problems with the person's relationships, employment and the law.

Sustainability: The likelihood of a program, coalition, or activity to continue over a period of time, especially after grant monies disappear. Sustainability is not about maintaining strategies but about achieving and sustaining positive outcomes.

T

Target group: Persons, organizations, communities or other types of groups that a program or project is intended to reach.

Technical Assistance: Services provided by professional prevention staff intended to provide technical guidance to prevention programs, community organizations and individuals to conduct, strengthen or enhance activities that will promote prevention.

U

Universal intervention: Universal prevention interventions take the broadest approach and focus on the general public or a wide population that was not identified based on risk.

V

W

Wellness: A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.

X

Y

Z

Appendix 3: IMPORTANT DATA SOURCES

- Information Sheet 2.4 National Data Sources

National Data Sources

***Behavioral Risk Factor Surveillance System (BRFSS),* Centers for Disease Control and Prevention (CDC)**

www.cdc.gov/brfss/

This annual survey, developed in 1984, collects demographic data on adults and information on alcohol use. The sample is national. States can add their own questions.

***Monitoring the Future (MTF),* National Institute on Drug Abuse**

www.monitoringthefuture.org

MTF is an annual survey of the "behaviors, attitudes, and values" of young people. Information is available on the incidence and prevalence of substance use, as well as other related issues, including perceived harm, disapproval of use, and perceived availability. It has a national sample; regional data are also available.

***National Survey on Drug Use and Health (NSDUH),* Substance Abuse and Mental Health Services Administration (SAMHSA)**

www.oas.samhsa/nsduh.htm

NSDUH is an annual survey that looks at the incidence and prevalence of alcohol and drug use among different age groups. Data is collected from household members and sorted by ages: 12-17, 18-25, 26-34, and over 35. A national sample is used; regional and state data are also available.

***Youth Risk Behavioral Surveillance System (YRBSS),* Centers for Disease Control and Prevention**

www.cdc.gov/nccdphp/dash/yrbs

The YRBSS assesses teenagers' incidence and prevalence of substance use, as well as other health issues, including sexual activity, vehicle safety, weapons, violence, and suicide. It measures behavior versus knowledge/attitudes. YRBSS uses a national sample of student's grades 9-12; some state and local data are also available

***Fatal Accident Reporting System (FARS),* National Highway Traffic Safety Administration**

http://www-fars.nhtsa.dot,gov/Main/index.aspx

FARS collects the following information annually from a national sample about deaths resulting from motor vehicle collisions: alcohol and drug involvement and major demographic characteristics.

***Drug Abuse Warning Network (DAWN),* Substance Abuse and Mental Health Services Administration**

www.samhsa.gov/data/DAWN.aspx

DAWN collects information annually from a nationally representative sample of patients in hospital emergency departments and from deaths recorded in medical examiners' reports about age, other demographics, and major substances of abuse.

***National Longitudinal Study of Adolescent Health,* National Institute on Child Health and Human Development**

www.cpc.unc.edu/projects/addhealth

This is "a longitudinal study of a nationally representative sample of adolescents in grades 7-12 in the United States during the 1994-95 school year." Information was collected on the influences of individual and environmental factors on health and health-related behavior in such areas as diet, physical activity, health services use, morbidity, injury, violence, sexual behavior, contraception, sexually transmitted infections, pregnancy, suicidal intentions/thoughts, substance use/abuse, and runaway behavior. Four follow-up surveys were conducted in 1996, 2001-2002, and 2007-2008. Information was also collected from parents, siblings, friends, romantic partners, fellow students, and school administrators.

***National Household Education Survey (NHES),* National Center for Education Statistics**

www.nces.ed.gov/nhes

This is a survey about adult education and lifelong learning, civic involvement, early childhood education and school readiness, household library use, parent involvement in education, and school safety and discipline. It uses a national sample of household members, depending on the topic (i.e., parents of children in grades 3-12 and youth in grades 6-12 participates in the School Safety and Discipline survey).

***National Crime Victimization Survey (NCVS),* Bureau of Justice Statistics**

www.icpsr.umich.edu/NACJD/NCVS

This survey, conducted annually since 1973, collects data on the frequency and nature of rape, sexual assault, robbery, aggravated and simple assault, theft, household burglary, and motor vehicle theft. It uses a national sample of primarily adults, although youth data are also available.

***School Crime Supplement to the National Crime Victimization Survey,* National Center for Education Statistics and Bureau of Justice Studies.**

http://www.icpsr.umich.edu/icpsrweb/NACJD/series/95/studies/28201?paging.startRow=26

This survey of household members who had attended school during the preceding six months collects information about the experiences with and perceptions of crime and violence that occurred inside the school, on school grounds, or on the way to or from school, as well as preventative measures used by schools and school rules, afterschool activities, availability of drugs and alcohol at school, and other related issues. It was conducted in 1989, 1995, 1999, 2005, and 2009, and uses the same national sample as the National Crime Victimization Survey.

***U.S. Census,* U.S. Census Bureau**

www.census.gov

This survey collects demographic data on adult household members, including population, race or ethnicity, age, income, education, and number of children. It is conducted every 10 years (interim estimates available) with national, regional, state, community, and census tract samples.

State Data Sources

Center for Disease Control and Prevention (CDC): Sortable Stats

http://www.cdc.gov/program/data/index.htm

Sortable Stats is an interactive data set composed of 20 behavioral risk factors and health indicators. The site compiles state-level data for all 50 states and Washington D.C., from various CDC and other federal sources into a format that allows users to view, sort, and compare data by state, federal, or geographical regions; view data by demographic categories and historical trends for states: and save graphs and maps as images that depict state trends and incidence rates.

National Library of Medicine, National Information Center on Health Services Research and Health Care Technology

http://www.nlm.nih.gov/hsrinfo/state_resources.html

This site provides brief descriptions and links to a wide range of state-level data, tools, and statistics. In addition to links to specific state resources, links also are included to federal and other sources of state data.

Local Data Sources

RI Student Survey (RISS)

The Rhode Island Student Survey (RISS) is a risk and prevalence survey that is administered bi-annually in nearly every middle and high school.

The RI Behavioral Health, Developmental Disabilities and Hospitals (RI BHDDH), to continue strengthening community capacity to address youth substance abuse and other risk taking behaviors, is implementing the RI Student Survey in RI middle and/or high schools across the state. The RISS collects survey information about substance use attitudes and behaviors from middle and/or high school students. The survey is completely voluntary and there is no penalty of any kind for students who do not participate in the RISS. The survey contains questions regarding attitudes, behaviors, and beliefs about alcohol and drug use in addition to basic demographic questions. All answers are strictly confidential. No names will appear on the survey and finding are reported in the aggregate, The RISS is designed to gain knowledge to improve the lives of young people, support program funding and resources to reduce youth high-risk behavior(s) and assist communities and schools to provide appropriate and effective services for youth.

RI State Epi Outcomes Monitoring Workgroup (SEOW)

The SEOW develops state and community profiles describing all 39 Rhode Island municipalities. The three components of these profiles are (1) Demographic and Substance Use Summary; (2) Community Comparisons; and (3) Alcohol Time Trends. Current profiles can be accessed at www.riprc.org/communityprofiles.

Police Reports

Police incident and arrest reports are filed and maintained by local and state law enforcement agencies (including some private security agencies, such as university police departments). Incident reports are filed when no arrest is made or citation issued. Incident and arrest reports typically contain a great deal of narrative information. Departments may be willing to generate summaries of drug- and alcohol-related arrests and incidents. Some states also publish annual summaries based on these reports. For assistance with criminal justice data, contact your state's Statistical Analysis Center. Contact Information for these centers can be found online through the Justice Research and Statistics Association at www.jrsa.org/sac/.

School Incident Records and Discipline Reports

These narrative reports provide information on incidents and disciplinary actions in public schools, including those involving the use, possession, or sale of substances. The data are often aggregated at the building, district, and state levels.

Court Records

Court Records can provide information on juvenile controlled-substance offenses, such as drug possessions, conspiracy, possession of a hypodermic-needle, and possession near a school.

Medical Examiner or Coroner Data

Most states require a medical examiner's or coroner's report for each person whose death resulted from violence or injury. These reports often contain the results of tests administered to determine if the deceased had used drugs or alcohol at the time of death. The reports are collected by County and State Medical Examiner's Offices, and County Coroner's Offices

Hospital Discharge Data

Hospital discharge data are collected on every person discharged from a hospital. These may be able to provide some information on injuries and diseases related to substance use. Some states aggregate these data at the state level.

Emergency Department Data

Activity records and medical logs are kept by hospital emergency departments. They may contain information on whether an emergency department visit was drug- or alcohol-related.

Emergency Medical Services Data

"Trip reports" or "run logs" maintained by emergency medical and ambulance services every time they transport a patient may include information on whether the incident was drug- or

alcohol-related. This information is often not aggregated in a Jurisdiction, sometimes not computerized, and, as with all medical information, subject to confidentiality requirements.

Newspapers

While not scientific, using "newspaper epidemiology" to identify the scope and nature of local drug and alcohol problems can provide a valuable and compelling picture of your community. Pay special attention to drug- and alcohol-related crimes, as well as the police report section of the newspaper in smaller communities. Many newspapers now have online archives, which allow their articles to be searched. Commercial database providers can also search newspapers by topic.

Adapted from SAMHSA's Substance Abuse Prevention Skills Training (SAPST) Data Sources List.

Appendix 4: RESOURCES, TOOLS, AND TEMPLATES

- Sample By-Laws
    - Portsmouth (Local)
    - South County (Regional)
- Sample Memorandum of Understanding
- Sample Passive Consent Form
- Sample Strategic Plans
    - R7 Strategic Plan
    - RPTF Strategic Plan Review Sheet & Scoring

BY-LAWS
PORTSMOUTH PREVENTION COALITION
(revised 02/26/2014)

ARTICLE I - NAME

The name of this organization is the Portsmouth Prevention Coalition.

ARTICLE II - MISSION

The Portsmouth Prevention Coalition is a coalition of community members interested in coordinating and designing strategies addressing tobacco, alcohol and other drug abuse with the primary goal of reducing youth substance abuse and overall substance abuse rates to help create a health, responsible and safe community.

ARTICLE III - MEMBERSHIP

The former Portsmouth Substance Abuse Prevention Task Force, renamed Portsmouth Prevention Coalition, was created through the authorization of the Portsmouth Town Council in compliance with RI Law Chapter 16-21.2 – The Rhode Island Substance Abuse Prevention Act. Local government appointed the Portsmouth School Department as the fiduciary agent. The Coalition is its own entity, independent of local government, with the power to control the programs and allocated funds under the Rhode Island Substance Abuse Prevention Act. The Coalition and its decisions and allocation of funds are not required to be reviewed by or receive approval of the local government.

Membership is open to individuals in the public and private sector of Portsmouth and to representatives of the required agencies by invitation or application. The Coalition shall consist of a minimum of seven (7) members and a maximum of twenty-five (25). Membership should include, but not be limited to representatives from interested citizens, parents, students, teachers, businesses, school department, elected officials, religious institutions, minorities, youth organizations, medical community, handicapped, police department, elderly and community development groups. The Coalition shall have even representation in as far as possible between the aforementioned groups. Members will be listed by only one category from the above list and have only one vote. The Coalition Coordinator will keep the Division of Behavioral Healthcare, Developmental Disabilities & Hospitals(BHDDH), , informed of any changes in the membership.

Membership on the Coalition can be terminated in one of three ways. The procedure of termination must include written notification to or by the member.

A. Resignation

B. The Coalition is intended to be a working task force with regularly scheduled monthly meetings. Any member missing three (3) consecutive scheduled meetings without prior excuse shall be removed from the Coalition membership list.

C. Any Coalition member who shall engage in any activity that may be considered detrimental to the objectives of the Coalition may be removed by a 3/4 vote of the voting members present at a regularly scheduled meeting.

The membership term shall be for an unspecified length of time to be terminated by one of the aforementioned methods.

ARTICLE IV - OFFICERS

The officers of the Portsmouth Prevention Coalition shall be the Chairperson and the Vice Chairperson and Secretary. The term for these officers shall be for two (2) years to run from October through September.

ARTICLE V - NOMINATION & ELECTION OF OFFICERS

Nominations will be made at the regularly scheduled August or September meeting. Any current member may make a nomination and second from the floor. Any person being nominated must be a current member of the Portsmouth Prevention Coalition.

Elections will be held at the regularly scheduled September meeting. A simple majority vote of the voting members present will be required for election. Means of election, either by voice, arm or written ballot shall be decided by the members just prior to the vote.

Vacancies created by the resignation of a current officer shall be filled within three (3) months, preferably at the next regularly scheduled meeting, and will require a simple majority vote of the voting members. The newly elected officer shall complete the un-expired term, at which time nominations and elections as stipulated above shall take place.

ARTICLE VI - DUTIES OF OFFICERS

The duties of the **Chairperson** shall be as follows:

A. to preside at all regularly scheduled meetings.
B. to represent the Coalition in the community-at-large.
D. to act as liaison with the Town Council and the School Committee in conjunction with the Coordinator.

The duty of the **Vice Chairperson** shall be to serve as Chairperson in the event of the elected Chairperson's absence.

ARTICLE VII - OTHER RESPONSIBLE AGENTS

Coordinator: A Coordinator, hired by the Town Council, will serve as secretary and statewide liaison to the Task Force. He/she will be the contact person for the Coalition within the Department of BHDDH and will also perform B & C of Article VI in conjunction with the Chair.

Fiduciary Agent: The Town Finance Director will designate a School Department employee member as liaison with that office for the purpose of generating and signing vouchers, and accounting for Coalition funds.

ARTICLE VIII - MEETINGS

Meetings will be held on a monthly basis no less than eight (8) times per year, dates to be decided at the June meeting. Changes to the yearly schedule of meetings may be made by a majority vote of the Coalition. Each Coalition member shall receive by mail, or e-mail, a meeting notice and agenda at least one (1) week prior to the meeting.

The voting members present shall constitute a quorum of the entire membership, providing there are at least three (3).

Unless inconsistent with these by-laws or otherwise decided by the membership, all meetings shall be conducted in accordance with Robert's Rules of Order.

ARTICLE IX - VOTING

Voting on any valid motion of the floor shall be limited to the active membership present. In order to allow for fair and equitable voting the following guidelines will be in effect whenever the vote has a direct bearing on an individual organization:

A. If any individual has a vested interest in the motion on the floor, their voting rights for that motion shall be suspended.
B. If an organization has a vested interest in the motion on the floor the voting rights of all members representing that organization shall be suspended for the purpose of that vote.

For the purpose of A and B above, a vested right shall be interpreted to mean financial consideration or commercial benefit.

Voting by proxy is not permitted on any motion.

ARTICLE X - SUBCOMMITTEES

Subcommittees shall be established as necessary for specific tasks as may arise and shall be appointed by the Chairperson based on volunteers and expertise available. The subcommittee shall be dissolved upon completing of the appointed task.

ARTICLE XI - AMENDMENTS

Amendments to the by-laws shall be made by a simple majority affirmative vote of the active membership at a duly called meeting of the membership provided the membership receives notice of not less than seven days before the date of said meeting. Amendments take effect immediately upon approval as stated herein.

ARTICLE XII-URGENT EXPENDITURES

In the event of expenditure for items or services of an immediate nature that cannot wait until the next scheduled Prevention Coalition meeting, the executive committee which is the chair, vice-chair and secretary, may vote to approve such expenditure NOT to exceed $500.
The expenditure will be reviewed at the next Prevention Coalition meeting and voted upon for sanctioned approval by the majority and entered into the minutes as such.

South Count Regional Coalition

Bylaws
DRAFT

Article I: Name

This organization shall be known as the ***South County Regional Coalition***.

Article II: Mission and Vision Statement

Mission: Bringing together partners to support positive behavioral health and wellness for youth and adults.

Vision: A safe and healthy lifestyle for the South County community

Article III: Goals

The Coalition has the following goals:

1. To increase the use of evidence-based policies, practices and programs by municipal substance abuse prevention coalitions across the lifespan, as well as among various sectors and community stakeholders (schools, law enforcement, prescribers of opioid medications) based on the findings of the municipal needs assessments;

2. Implement environmental change strategies to raise awareness of potential for harm, and reduce youth access to harmful legal products (e.g., products which might be legal for use by a segment of the population such as adults but which are not legal and are potentially harmful to others such as youth), and

3. Use media and communication strategies to promote positive behavioral health, increase the perception of risk or harm from substance use and correct normative misunderstandings of the norm among youth and young adults

Article IV: Membership

Membership in the Coalition is open to any person or organization in the county area that wishes to participate in developing and implementing strategies to reduce substance abuse in

South County. To ensure a broad cross-section of local representation, at a minimum, the following sectors of the county area will be represented:

o Business	o Education
o Safety	o Medical/health
o Government	o Community/family supports

No individual or organization may be viewed as representing more than one sector. There is no limit to the number of individuals or organizations representing each sector.

Article IV: Meetings

Regular meetings of the Coalition will be held monthly. Additional meetings may be called by the Chairperson as may be necessary to conduct business of the Coalition or accomplish assigned tasks.

Committees of the Coalition will meet at a time and place determined by the chair and the members of each committee.

Article V: Officers

The officers of the Coalition will be Chairman, Vice-Chairman, and Secretary. The duties of each position are as follows:

Chairperson: Develop an agenda and preside over meetings of the Coalition and serve as spokesperson for the coalition when communicating with the media and other organizations; appoint standing and ad-hoc committees; and other duties as may be necessary for the effective functioning of the Coalition.

Vice-Chairperson: Serve as an assistant to the Chairperson and assume the duties of the Chairperson should that person be unable or unavailable; and serve as chair of committees as may be assigned by the Chairperson.

Secretary: Take or provide secretarial help to maintain accurate minutes of Coalition meetings; prepare correspondence on behalf of the Coalition; maintain a membership roster for the Coalition; and serve as chair of sub-committees as may be assigned by the Chairperson.

Election of officers will occur at the annual meeting of the coalition. Officers may succeed themselves for a maximum of two terms. A term is defined as two years.

Article VI: Relationship to County Collaboration Boards

This coalition was formed as a partnership between the Department of Behavioral Health and RI Student Assistance Services.

Article VI: Sub-Committees

Article VII: Strategies

The Coalition and its members will employ multiple prevention strategies, involving representatives from various community sectors, to address behavioral health and substance abuse issues in the county area. These strategies will address the multiple domains of Community, Family, School and Individual/Peer. Whenever possible, proven and research-based prevention strategies will be employed.

Article VIII: Funding and Finances

A major task of the Coalition will be to seek out funding and in-kind support to implement identified prevention strategies and will include federal, state, and local sources.

RISAS will serve as the fiscal agent for the Coalition. Duties will include the submission of grant applications to implement Coalition strategies, the management of funds and other resources, and ensure that funding adheres to all rules and guidelines of all funding sources on behalf of the Coalition.

Article X: Amendments

Any amendment to these by-laws may be adopted by a two-thirds (2/3) vote of the members present at any meeting, provided written notice of the proposed amendment and the date of such meeting shall have been given to the members at least two (2) weeks in advance.

MEMORANDUM OF UNDERSTANDING (MOU)

A Memorandum of Understanding, while not a legally binding document, does indicate a voluntary agreement to assist in the implementation plans of a grant funded collaborative project. The agreement is between the lead agency/applicant and a partnering entity. It generally defines the overall program goals and describes the collaborative nature and relationship between the identified project and MOU-referenced participant.

The initial paragraphs should contain the following information:

- **Name of project**
- **Name of agencies involved in the MOU**
- **Identification of funding source**
- **Identification of grant period**
- **Project goals and key services to be provided**
- **Project outcomes to be addressed**

The body of the MOU should include the following five areas:

1) **Term and conditions of the MOU should address the timeframe of agreement and, if applicable, timetable for renewing commitment.**

2) **Identification of roles and responsibilities of the lead agency.**

3) **Identification of roles and responsibilities of the partnering agency.**

4) **Termination clause is very important as it defines how the agreement can be ended (i.e. by written 30 day notice).**

5) **Signatures of the agency representatives, including date signed, is located at the end of the MOU.**

SAMPLE

MEMORANDUM OF UNDERSTANDING
BETWEEN

NON PROFIT AGENCY
AND
COMMUNITY BASED ORGANIZATION

This Memorandum of Understanding (MOU), while not a legally binding document, does indicate a voluntary agreement to assist in the implementation of the plans described in the "Title of Project", a substance abuse prevention demonstration grant targeting high risk female adolescent populations. This grant is funded through the Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services, center for Substance Abuse and is expected to have a three year funding cycle.

Overall Project Goals, Services and Outcomes: very brief program overview

Term One: This MOU shall begin upon grant funding approval. The agreement is renewable from year to year, unless either party gives notice of intent to withdraw from the project.

Term Two: Agency Provisions: In addition to continuing the on-going program planning and review process of "Title of Project" the non-profit organization will provide the following services in specific support of this project:

a. b.
c. d.

Term Three: Agency Provisions: In addition to participating in the on-going planning and review process of the above mentioned project, the community based organization will provide the following services in specific support of this project:

a. b.
c. d.

Term Four: Termination: This MOU may be terminated by either party, for any reason, by giving 30 days written notice.

Non-Profit Agency Signature	**CBO Agency Signature**
Title	**Title**
Date	**Date**

Sample Passive Consent for the RISS:

Dear Middle School Parents or Guardians:

The School Department has received a grant from the RI Behavioral Health, Developmental Disabilities and Hospitals (RI BHDDH), to continue strengthening community capacity to address youth substance abuse. A requirement of this grant is that the RISS collects survey information about substance use attitudes and behaviors from 8th grade students. This survey is scheduled to be administered to 8th grade students during a PE/Health class.

Confidentiality: Completing the survey is completely voluntary. There is no penalty of any kind if a student does not participate in the survey. The survey contains questions regarding attitudes, behaviors, and beliefs about alcohol and drug use in addition to basic demographic questions. **All answers are strictly confidential.** No names will appear on the survey. We will never report to anyone how any individual has answered the survey; rather we report only aggregate responses.

Benefits: The information gained from the survey is used to:
1) improve the lives of our youth,
2) support program funding and resources to reduce youth high-risk behavior(s),
3) help provide even better services for youth.

Risks: Questions concerning alcohol, tobacco and drugs are about substances which are illegal for youth and may make some youth feel uncomfortable. Your child may decline to answer any question(s).

Alternative: The alternative is not to complete the survey.

If you have any questions regarding the survey, please contact:

Thank you for helping us collect this needed information.

Cordially,

Coordinator

Rhode Island Student Survey ~ Middle School

Please **PRINT** Student's Name:_____

Grade: _____ PE/Health teacher:_____ Date: _____

This form only needs to be signed and returned to the Main Office if you ***DO NOT*** want your child to participate in this survey.

.

❑***I DO NOT grant my permission for my child to complete this survey.***

Please **PRINT** Parent/Guardian's Name: _____

Parent/Guardian's Signature:_____

Developed by:

South County Regional Coalition

Strategic Plan for
January 1, 2018 – December 30, 2018

Developed on Nov. 1, 2017

Contents

Background

Substance Abuse Trends and Needs at the County Level

In considering trends and needs, these can be looked at in three dimension – substances that are being used, populations that are using them, and cultural forces and factors that are influencing use.

In terms of substances being used, the three areas of greatest concern are marijuana, alcohol, and heroin/fentanyl/opiates.

Concern around marijuana has grown significantly. This is in large part due to its increased accessibility, increased acceptability, expanded routes of transmission (and hence reduced detectability) and increased risks (due to laced or tainted marijuana). This concern was reflected in the stakeholder interviews, community survey, some of the school data (as it relates to marijuana use compared to alcohol use with respect to extent and age of first use), and the focus groups. Whether it is local growers, access to a parent's or older sibling's supply of marijuana, or otherwise, marijuana is seen as increasingly accessible in South County. The role of medicinal marijuana and legalization of it in several states has made its use more culturally acceptable and permissible. Many more individuals are seeing marijuana as natural, harmless to the individual, and safer than alcohol as it relates to consequences (drunk driving, unwanted sexual activities, etc.). Marijuana use is also seen as easier – edibles and vaping – amongst other means – enable individuals to use marijuana undetected. This does not mean that there is still not use in school bathrooms, parking lots, or just out in public (as some in the community stakeholder interviews mentioned), but simply that now not all use is as obvious or detectable as it may have once been. Finally, when there are significant concerns about marijuana use, it does seem that much of this concern relates to the potential lacing or tainting of marijuana with fentanyl or other chemicals that can cause serious harm, up to and including death. That marijuana is viewed as now being potentially fatal may start to have some influence on use and attitudes.

The second significant trend is **the opiate overdose crisis**. As in the rest of the country, it seems to South County residents that this issue started with over-prescription of pain medications and has migrated to now include heroin and fentanyl. There seems to be increased community awareness and growing policy changes as it relates to practices around prescribing prescription medication, but the impact of prescription medication misuse and illegal drug use in this area has been significant. The deaths resulting from overdose have shaken many communities – one pastor remarked that he had attended three funerals in the past year related to opiate overdoses.

This is an area where community data does not align with community perceptions in terms of the extent of emergency room visits and deaths resulting from overdose. That said, it is clear that in addition to the clear human impact on individuals and families, the crisis has also highlighted a new population at risk – young adults. The sense of **lack of hope and despair amongst 20-somethings** was noted by a number of key stakeholders and reinforced in part through the focus groups. To the extent that there can be any silver lining in this crisis, there is a sense that the "this can happen to anyone" perception is driving more conversations in homes and communities about the dangers of substance abuse and addiction.

The third "trend" is alcohol and it is listed as a trend because in many ways it is not a trend. From a community perception perspective, it appears that **concerns regarding alcohol – under age use, harm resulting from excessive use – remains pretty consistent**. While community survey results indicate that it is viewed as a significant problem, these concerns are not borne out in the focus groups or the stakeholder survey to the same extent. Some data do indicate that the problem of alcohol use is increasing – Washington County has the highest rates of alcohol impaired driving deaths of any county in the state and this number is increasing. The county also has the highest rate of binge drinking of any county in the state.

With respect to at risk populations, from an age perspective there is growing concern for youth starting at the middle school age level all the way through early adulthood. Interestingly, the notion of focusing on the very young (elementary school age students, etc.) seems to have taken a back seat to starting with middle schoolers and instead of stopping at high school, there is a growing concern for young adults. Within the young adult population, there is a sense that greater attention needs to be paid to those that are just out of high school that may not have a clear pathway forward, as well as college students and recent graduates. Many of these young adults are experiencing a lack of hope or optimism about the future and their future, sentiments raised in the stakeholder interviews and echoed by high school students in the focus groups.

In terms of other factors placing segments of the population at risk, there is general agreement though the stakeholder interviews that individuals living in poverty experience significant risk factors as well as lack of access to protective factors. Poverty in South County is characterized by small enclaves surrounded by communities with significantly more wealth. These enclaves can be cut off geographically, culturally, and otherwise from the larger community. Lack of public transportation further isolates these residents and limits their participation in and access to programs, services, resources, and supports that mitigate risk and strengthen resilience.

A related factor placing many at risk is **social isolation**. Not only does this relate to individuals living in poverty, as described above, but also speaks to the larger disconnect that has been exacerbated by the impact of social media. Focus groups and stakeholder interviews each highlighted the notion of individuals having many social media friends but no one in actual real life that they could depend on or call for help.

Finally, **mental health and stress** are significant factors that are contributing to use of alcohol and other drugs and misuse of prescription drugs in South County. Individuals with co-occurring mental health diagnoses are at greater susceptibility for substance abuse and have less access to treatment resources when they do seek help. These individuals are also frequently dealing with other factors related to their illness, including poverty, homeless, etc. In addition, school surveys bear out the notion that youth are experiencing significant amounts of stress and distress. More than ½ of students in grades 3-5 and nearly 2/3 of students in grades 6-12 report high levels of stress when asked questions such as "how stressful is school for you? and how often do you worry about things in your life?" And while Washington County has the lowest rate of self reported poor mental health days, the county average is increasing.

Lastly, there are some trends that are driven by cultural changes in society. First and foremost is the **increasing acceptability of using marijuana**. There is an increasing sense that it is ok to smoke marijuana given that it is now viewed by many as a medicine and still others as a natural herb that is legally permissible to possess and use in several states in the US. The rapidly expanding permissive attitudes about marijuana seem to be contributing to its increased use. The other trend, which to some extent countervails this trend, is the high potency and lethality of drugs. The overdoses and accidental deaths associated with drug use, which have been skyrocketing, have driven more conversations in the home and community about drug use, as well as helped to convey that all are at risk, despite income, race, or geography.

The South County Regional Coalition commenced on January 1, 2017 with a grant from the RI Department of Behavioral Health. The Director of the coalition is Kathleen Sullivan, a Certified Prevention Specialist with over fifteen years of experience in coalition building.

Services are delivered through six, defined, federal strategies. The region will demonstrate that programming and funding will cover five of six services areas delivered within the region through the defined federal strategies listed below:

- **Information dissemination**-providing knowledge and awareness: e.g. health fairs, media campaigns, brochure, resource directories, Public Service Announcements;
- **Education**- two-way communication between educator/facilitator and participant: e.g. classroom, small group sessions, parenting/family classes, education programs for youth;
- **Alternatives**- provides constructive and healthy activities that exclude alcohol, tobacco, and other drug use: e.g. drug-free social and recreational activities, community drop in centers, mentoring programs, community service activities;
- **Environmental-** establishes/changes community standards, codes, and attitudes: e.g. school drug policies, product pricing, social norms, technical assistance to maximize local enforcement;
- **Community-**based process- aims to enhance the community to more effectively provide substance abuse prevention services: e.g. systemic planning, community teambuilding multi-agency coordination/collaboration, community and volunteer training assessing service and funding.

Vision

A region in RI where every community promotes programs that support all South County residents, enabling them to make safe and healthy choices for physical and mental wellness.

Mission

Bringing together partners to help community members and leaders create a region where youth and adults enjoy positive behavioral health.

Values of the South County Prevention Coalition

Partnership	Teamwork	Empowerment	Ethical
Communication	Respect	Safety	Attitude
Community	Achievement	Diversity	Competence

Championing the Cause

The South County Prevention Coalition is a new entity with room for growth. Members currently represent years of experience in community coalition building. These dedicated and committed community leaders bring to the newly formed regional coalition a wealth of experience with the Strategic Prevention Framework and the understanding of risk and protective factors in their communities.

The coalition is excited about the opportunity to work together as region to make an impact on the region as a whole rather than simply working in silos at the municipal level. Members have already joined forces to educate the public about the risks of marijuana, alcohol and vaping at the Washington County Fair, for instance.

The coalition has active youth coalitions who are commencing a new project of working as a Regional Youth Task Force with the support of leaders from the South County Regional Coalition.

Communication Plan

What groups do we need to serve most?	What do they need to hear from us?	What is the best way to find and communicate with them?	When will we communicate with them? How often?	How will we know if they have heard our message?
Parents and community leaders.	*Parents need to learn more about the risks and harms of emerging drug use by youth. They also need to know the tools required to prevent and reduce youth substance use.*	*Where are they? Do they communicate online? In person? Are there networking groups, events, or trainings that you can participate in to give an opportunity to communicate with them?*	*We will create an online monthly newsletter*	*Success will be measured through youth use rates, perception of harm*

Objectives and Priorities

The needs assessment for the South County Regional Prevention Coalition indicates that the issue of alcohol and marijuana use is significantly more widespread than opiates. The following are areas that the coalition will develop objects, SMART goals and outcome measures:

Marijuana Education

Policy Initiatives

Better access to Youth Mental Health and Substance Use Treatment

Engage URI Students and Faculty in Coalition

Reduce Access to Prescription Drugs

Address Youth Stress

Communication Disconnection between Parents and Teens

Youth Disconnection

Driving Under the Influence (DUI)

Promote Prevention Work in Community

Risks and Opportunities

Scope of work: Broad deliverables	Assess what stays the same	Assess what is different	Who is impacted by the change?
• Shared media • drug take back strategies • collaboration- shared programming • strength in numbers • conference planning • bigger bang buck, shared skill sets • shared funds	• local coalitions • data reporting requirements • local leaders • doing same type of work • same challenges	• less money to communities • less focused on community specific programming, not as tailored, losing local flavor- e.g. media and placement, challenges for equal opportunities for local coalitions, clear role for each funding source • tracking time allocated based on budget- what is actually RISAPA-, more content areas and less clear • how local coalitions are funding • power dynamic	• local coalition members,- lack of understanding of benefit • towns, students- less programming • key leaders don't like it- makes it had to maintain relationships, coordinator

Who is responsible for communicating changes?	What is gained by the change?	What is lost by the change?	What info/training will need to be in place to move toward readiness?
• local coordinators • regional coordinators • coalition members but will need training and support to get buy in	• shared resource • sharing information and skills • networking • media strategies • stronger visibility for prevention • access to other prevention leaders working together • communities know what the coalitions do and the importance • opportunities for innovation • new funding sources	• loss of identity • loss of control and voice, • loss of funding • under reporting the work due to change in RISAPA service delivery- still doing but not funded any more • funding going to different agencies- losing benefit- towns may not see the benefit to the match of 20% • key leaders not happy, • town ownership weakened • matching in-kind resources at risk • losing ground on work and success • frustration of coalition members and coordinators • unsure of future, fear of what the future will bring • services might go away • may lose jobs • losing infrastructure and relationships • concerned community will no longer want to collaborate,	• bottom line funding amounts • talking point-what it is and what it's not, • need to spell it in a community friendly way • clarify what is involved with the planning phase • be clear what we don't know • share what can be exciting, • research trends in prevention funding • clarify how we can change the message.

		• data sources are going away	

Work Plan

ALCOHOL

Need: Alcohol is the most widely used and socially accepted substance in South County
Goal: Reduce the use of alcohol by youth aged 12-25 in the South County Region
Objective: Reduce the percent of youth reporting past 30-day use of alcohol by 3% by December 2019.
Strategy: Info Dissemination, community based process, education, environmental

Activity	Responsible Party	Due Date	Measure

Prepare and distribute online monthly parent newsletter	Regional Director/Municipal Coordinators	12/31/2018	# distributed; community feedback
Strengthen partnerships with local/regional/statewide community based, civic and faith-based organizations	Regional Director/Municipal Coordinators	12/31/2018	list of potential partners; # of outreach attempts; # formal partnerships
Partner with local law enforcement to support compliance checks and party patrols	Regional Director/Municipal Coordinators	12/31/2018	# Law Enf agencies contacted; #compliance checks; # party patrols
Strengthen partnerships with local HEZ	Regional Director/Municipal Coordinators	12/31/2018	# of outreach attempts; # mtgs
Develop Regional Youth Coalition	Municipal Coordinators	6/30/2018	# youth participating; # communities represented; # events planned

MARIJUANA

Need: Marijuana is increasingly used by youth in South County
Goal: Reduce the use of marijuana in the South County Region
Objective: Reduce the percent of school-aged youth reporting past 30 day use of marijuana by 3% by December 2019.
Strategy: Educate community about risks and reduce access

Activity	Responsible Party	Due Date	Measure
Prepare and distribute online monthly parent newsletter	Regional Director/Coordinators	12/31/2018	# distributed; school and parent feedback
Life of an Athlete Program	Regional Director/Coordinators	6/30/2018	# attendees at trainings; # schools; pre/post tests; evaluations; updates/changes in policies
Develop regional Marijuana media campaign/participate in statewide media campaign	Regional Director/Coordinators	9/1/2017	# campaigns; # reached; # locations; community feedback
Strengthen partnership with statewide organizations like MADD to collaborate on community events	Regional Director/Coordinators	12/31/2018	# meetings; # events; evaluations
Hidden in Plain Sight Program	Regional Director/Coordinators	12/31/2018	# outreach materials; # outreach opportunities; # events; # attendees;
Strengthen partnerships local/regional/state community based, civic and faith-based	Regional Director/Coordinators	12/31/2018	list of potential partners; # of outreach attempts; # formal partnerships
Strengthen partnerships with local HEZ	Regional Director/Coordinators	12/31/2018	# of outreach attempts; # mtgs

Promote VAASA Conference	Regional Director/Coordinators	6/30/2018	# youth attendees; evaluations
Distribute Raising Healthy Teens Quarterly Newsletter	Regional Director/Coordinators	6/30/2018	# distributed; # schools and pediatric offices participating; evaluation

MENTAL WELLNESS

Need: Mental Health treatment and support problem identified by Needs Assessment

Goal: Advocate for treatment for those with Mental Health challenges.

Objective: Improve supports for families with mental health issues.

Strategy: Information dissemination, education, alternatives, Prob ID and referral

Activity	Responsible Party	Due Date	Measure
School Speakers/Assemblies	Regional Director/Coordinators	6/30/2018	# of assemblies;# of youth attending
Health Fairs	Regional Director/Coordinators	12/31/2018	# of fairs; material distributed
Physician outreach and information regarding SBIRT	Regional Director/Coordinators	2/28/2018	# of outreach attempts; # mtgs
Mindfulness Programs in schools	Regional Director/Coordinators	6/1/2018	#schools participating

Partner with local mental health and health agencies	Regional Director/Coordinators	12/31/2018	list of potential partners; # of outreach attempts; # formal partnerships
Media campaign(s)	Regional Director/Coordinators	12/31/2018	# campaigns; # reached; # locations; community feedback

OPIATES

Need: The progressive nature of opiate addiction often begins with prescription medication abuse.

Goal: Reduce the use of opioids in South County region

Objective: Reduce opioid use by 3% by 2021

Strategy: Information Dissemination, community based process, environmental, Physical Design

Activity	Responsible Party	Due Date	Measure
Implement STR Program/Project Lazarus	Regional Director/Municipal Coordinators	3/31/2018	# attendees; pre-post; evaluations; # events
STR - Classroom presentations/Target 10th grade	Regional Director/Coordinators	3/31/2018	# attendees; # materials distributed
Community Trainings (in collaboration with URI, Hospital, Pharmacy)	Regional Director/Coordinators	12/31/2018	# trainings; # attendees; # partnerships; evaluations

Develop Regional media campaign (CLD)/participate in statewide media campaign	Regional Director/Coordinators	12/31/2018	# campaigns; # reached; # locations; community feedback
Promote RX Drop Boxes	Regional Director/Coordinators	12/31/2018	# materials developed; # venues used; amount collected
Participate in DEA Drug Take Back	Regional Director/Coordinators	10/2017; 4/2018; 10/2018	# materials developed; # venues used; amount collected
Strengthen partnership with statewide civic groups to collaborate on community events	Regional Director/Coordinators	12/31/2018	# meetings; # events; evaluations
Hidden in Plain Sight Program	Regional Director/Coordinators	12/31/2018	# outreach materials; # outreach opportunities; # events; # attendees; evaluations
Strengthen partnerships with community based, civic and faith-based organizations	Regional Director/Coordinators	12/31/2018	list of potential partners; # of outreach attempts; # formal partnerships
Partner with Schools regarding placing Nalaoxone boxes	Regional Director/Coordinators	12/31/2018	# Schools contacted; # Naloxone boxes
Strengthen partnerships with local HEZ	Regional Director/Coordinators	12/31/2018	# of outreach attempts; # mtgs

COMMUNITY NAME:

RI REGIONAL PREVENTION TASK FORCE: LOCAL STRATEGIC PLAN GUIDANCE DOCUMENT REVIEW FORM/ reviewer initials

SECTION I – SPF STEP ONE: ASSESSMENT

Table 1 - SCORING ANCHORS
ASSESSMENT OF COMMUNITY NEED/REVIEW OF POPULATION NEEDS

INSUFFICIENT: fails to address the minimum required elements	**MEETS REQUIREMENTS**: addresses the minimum required elements	**EXCEEDS REQUIREMENT**: addresses all elements including expanded or optional items
No discussion of the sources of population level data that were reviewed	Described the data reviewed and the source of the data	Described the data reviewed and the source of the data which included the community profiles and additional, relevant population level data
No discussion of trend data	Discussion of trend data, limited to trend data provided to the communities by the state	Discussion of trend data provided to communities by the state as well as additional (external) trend data.
No discussion of review of sub population data	Discussion of sub-population data but no link back to population level need; **OR** a compelling argument was presented that no sub-population(s) was/were identified after review of data	Discussion of sub-pop data which included links back to population level need

1. ASSESSMENT OF COMMUNITY NEEDS/Review of Population Data

Did the regional coalition describe the data sources (including the community profile) that were utilized to determine population needs within the community? See scoring anchors above. If any of the sections are insufficient, please describe what revisions would be needed to meet requirements in the comments section.

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

a. Was trend data (multiple data points/several years of data) considered?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

b. Was sub-population data available and, if so, was it used to determine population level need?

☐ Insufficient ☐ Meets Requirements ☐ Exceeds Requirements

Comments:

COMMUNITY NAME:

RI REGIONAL PREVENTION TASK FORCE: LOCAL STRATEGIC PLAN

GUIDANCE DOCUMENT REVIEW FORM/ reviewer initials

SELECTION OF THE PRIORITY PROBLEM AND THE PRIORITIZATION PROCESS

Table 1-A - SCORING ANCHORS
THE PRIORITY PROBLEM and CONSEQUENCES

INSUFFICIENT: fails to address the minimum required elements	**MEET REQUIREMENTS**: addresses the minimum required elements	**EXCEEDS REQUIREMENTS**: addresses all elements including expanded or optional items
Did not describe why the region's priority problem was selected; or presented only summary data with no analysis	Described why the region's priority problem was selected and used one or more of the analyses from the Guide to the Community Needs Assessment as a rationale for the decision (trend, magnitude or benchmarking)	Described the priority problem and the rationale for its selection using multiple analyses from the Guide to the Community Needs Assessment **AND** additional data or analyses
No specific discussion of the review any consequence associated with the priority problem	Described the review of consequences of the priority problem and efforts to compare to the state or community is described even if no priority consequence is identified	Described the review of consequences related to the priority problem; discussed magnitude and addressed at least one other factor such as trend
No discussion of the impact of consequence(s) upon the sub-populations vulnerable to health disparities	Discussion of the review of consequence(s) data and impact upon sub-populations vulnerable to health disparities; **OR** identification of data gaps; **OR** provided a compelling argument that no sub-pops were identified during assessment	Discussion and analysis of impact of consequence upon more than one sub-populations population vulnerable to health disparities; **OR** description of the engagement of community leaders from sub-populations vulnerable to health disparities in analysis of data

COMMUNITY NAME: _____

RI REGIONAL PREVENTION TASK FORCE: LOCAL STRATEGIC PLAN GUIDANCE DOCUMENT REVIEW FORM/ reviewer initials _____

A. THE PRIORITY PROBLEM

Did the regional coalition identify the priority problem selected and provide a rationale for the selection and prioritization process?

☐ Insufficient ☐ Meets Requirements ☐ Exceeds Requirements

Comments:

B. CONSEQUENCE(s) RELATED TO THE PRIORITY PROBLEM –

Did the regional coalition describe the comparisons (e.g., rates/rankings, as appropriate) of the region to the state, a comparison community or the county?

☐ Insufficient ☐ Meets Requirements ☐ Exceeds Requirements

Comments:

Did the regional coalition describe the impact of consequences associated with the priority problem selected on sub-populations vulnerable to health disparities?

☐ Insufficient ☐ Meets Requirements ☐ Exceeds Requirements

Comments:

COMMUNITY NAME:

RI REGIONAL PREVENTION TASK FORCE: LOCAL STRATEGIC PLAN

GUIDANCE DOCUMENT REVIEW FORM/ reviewer initials

Table 1-B - SCORING ANCHORS
CONSUMPTION PATTERNS

INSUFFICIENT: fails to address the minimum required elements	**MEETS REQUIREMENTS**: addresses the minimum required elements	**EXCEEDS REQUIREMENTS**: addresses all elements including expanded or optional items
Did not identify a community level priority consumption pattern or failed to indicate that none emerged after review.	Described at least one priority community level consumption patterns and compared it to the state; **OR** articulated that the review process did not yield a specific consumption pattern.	Described more than one community level consumption pattern
Did not describe the type of consumption data reviewed	Described review of all relevant consumption data provided in the Guide to the Community Needs assessment including quantitative and required qualitative data collected	Described review of all relevant consumption data provided in the Guide to the Community Needs Assessment **AND** added additional consumption data (quantitative or qualitative)
Did not describe comparisons of community consumption patterns	Described how the community level consumption pattern(s) compared to the state	Described how the community level consumption pattern(s) compared to the state **AND** another comparator such as comparison community or county data
Did not describe any factors considered in the selection of consumption pattern(s)	Described at least one factor considered in an effort to identity a priority the consumption pattern even if one did not emerge.	Described two or more factors considered in selection of consumption pattern(s)
No discussion of efforts to review consumption related data for any sub-population(s) identified	Discussion of the review of sub-population data related to consumption **OR** identification of a data gap **OR** a compelling argument that no sub-population was identified in assessment	Discussion and analysis of impacts on more than one sub-population **AND/OR** engagement of community leaders in analysis of data

C. PRIORITY CONSUMPTION PATTERN(s) – To what extent did the regional coalition describe a consumption pattern(s) related to the priority problem identified by the region and the process undertaken to select it*?*

Did the regional coalition identify a consumption pattern related to their selected priority problem?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

Did the description include data reviewed in the selection process?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

Did the regional coalition describe comparisons of the region to the state and, as applicable, a comparison community or the county overall?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

Did the regional coalition describe factors considered in the selection process?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

Was there discussion of consumption patterns and sub-populations vulnerable to health disparities?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

COMMUNITY NAME:

RI REGIONAL PREVENTION TASK FORCE: LOCAL STRATEGIC PLAN

GUIDANCE DOCUMENT REVIEW FORM/ reviewer initials

Table 1-C - SCORING ANCHORS
RISK and PROTECTIVE FACTORS

INSUFFICIENT: fails to address the minimum required elements	**MEETS REQUIREMENTS**: addresses the minimum required elements	**EXCEEDS REQUIREMENTS**: addresses all elements including expanded or optional items
No discussion of a priority risk or protective factor	Discussion of at least one priority risk or protective factor	Described more than one priority risk or protective factor
No discussion of data sources reviewed	Discussion of both quantitative and qualitative data sources reviewed	Discussion of both qualitative and quantitative data sources reviewed **AND** additional data sources not noted in the Guide to the Needs Assessment provided
No discussion of the region compared with the state or other comparator	Discussion of the community as compared to the state	Discussion of the community as compared to the state **AND** another relevant comparator
No discussion of the factors considered	Discussion of magnitude only	Described two or more factors considered in selection of the risk or protective factor(s) in addition to magnitude and benchmarking
No discussion of the impacts of risk or protective factors upon the sub-population identified	Discussion of the review of sub-population data related to risk or protective factors; **OR** identification of a data gap; **OR** a compelling argument that no sub-population was identified in assessment	Discussion and analysis of risk or protective factors related to any sub-populations identified **AND/OR** engagement of representatives of the sub-population in analysis of the data

PRIORITY RISK OR PROTECTIVE FACTOR(s) - Please identify which state identified priority community level risk or protective factors posed the greatest burden to the region. Please provide a rationale for the risk or protective factor(s) ultimately selected.

COMMUNITY NAME:

RI REGIONAL PREVENTION TASK FORCE: LOCAL STRATEGIC PLAN GUIDANCE DOCUMENT REVIEW FORM/ reviewer initials

Did the regional coalition identify at least one priority risk or protective factor?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

Did the regional coalition describe the community level risk or protective factors reviewed and the types of data considered (both quantitative and qualitative)?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

Did the regional coalition describe any comparisons to the state and, as applicable, a comparison community?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

Did the regional coalition describe any other factors considered in the selection process for the priority risk or protective factor(s) (magnitude, cost to society, changeability)?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

Did the regional coalition describe the impact of priority risk or protective factors on sub-populations vulnerable to health disparities (if any were identified during assessment)?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

COMMUNITY NAME:

RI REGIONAL PREVENTION TASK FORCE: LOCAL STRATEGIC PLAN

GUIDANCE DOCUMENT REVIEW FORM/ reviewer initials

Table 1D - SCORING ANCHORS
ASSESSMENT OF COMMUNITY CAPACITY

INSUFFICIENT: fails to address the minimum required elements	**MEETS REQUIREMENTS**: addresses the minimum required elements	**EXCEEDS REQUIREMENTS**: addresses all elements including expanded or optional items
Did not describe the human resources available in the region	Described human resources available in the region including membership of the coalition, any relevant sub-committees/ad-hoc or working groups, substance abuse prevention vendor network and current substance abuse prevention activities with the community.	Described all elements from previous column, **AND** assessed sufficiency of current level of human resources to address priority problems and associated risk or protective factors.
Did not describe available fiscal resources	Described available fiscal resources	Described available fiscal resources and how they were leveraged
Did not describe any technical resources	Described current ability to collect, analyze and report on municipal level data and describe prevention skills and knowledge	Described all elements from prior column for both coalition staff **AND** volunteers
Did not describe any efforts to assess capacity to include or provide	Discussion of services currently offered that are culturally relevant/sensitive and meet any identified linguistic needs	Discussion of services currently offered across MULTIPLE sub-populations and analysis of availability of culturally and linguistically appropriate services

D. CAPACITY ASSESSMENT

To what extent did the regional coalition describe the assessment of regional coalition capacity, specifically resources and readiness.

1. Resources

   a. Did the regional coalition describe human, fiscal or technological resources?

   ☐ Insufficient ☐ Meets Requirements ☐ Exceeds Requirements

   Comments:

b. Did the regional coalition describe fiscal resources?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

c. Did the regional coalition describe technological resources?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

2. Community Readiness
   1. Did the regional coalition describe the level of community readiness to address the selected priority?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

2. Did the regional coalition provide information on respondents interviewed, by name, title and sector/stakeholder group represented?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

3. Did the regional coalition briefly describe key themes and describe the implications of these findings on selection of EBPs?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

4. Did the regional coalition identify capacity needs related to inclusion of or providing services to sub-populations vulnerable to health disparities

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

COMMUNITY NAME:

RI REGIONAL PREVENTION TASK FORCE: LOCAL STRATEGIC PLAN GUIDANCE DOCUMENT REVIEW FORM/ reviewer initials

Table 1E- SCORING ANCHORS
SPF STEP 1 - SUSTAINABILITY

INADEQUATE: fails to address the minimum required elements	**MEETS REQUIREMENTS**: addresses the minimum required elements	**EXCEEDS REQUIREMENTS**: addresses all elements including expanded or optional items
Does not address how key tasks associated with Step 1 might be sustained at the conclusion of the RPTF funding period	Briefly described how A) reviewing population level data to establish priorities; AND B) using data to select community level priority consequences, related consumption patterns and risk/protective factors to target with strategies, might be sustained post RPTF.	Sustainability plan contained all items described in the prior column and added additional tasks to be sustained

Please describe how key tasks associated with Step 1 might be sustained beyond the life of the Regional Prevention Task Force award. Consider and describe ways that the following tasks might be sustained without funds or with minimal funds at the conclusion of the RPTF funding period.

1. Did the regional coalition describe how the process of reviewing population level data to establish priorities for local prevention initiatives be sustained beyond the life of the RPTF (including sub-population data, where available)?

   ☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

   Comments:

Did the regional coalition describe a process for sustaining use data to select community level priority consequences, related consumption patterns and risk or protective factors to target with strategies?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

COMMUNITY NAME:

RI REGIONAL PREVENTION TASK FORCE: LOCAL STRATEGIC PLAN

GUIDANCE DOCUMENT REVIEW FORM/ reviewer initials

SECTION 2 – SPF STEP 2: MOBILIZATION AND CAPACITY BUILDING

Table 2-A - SCORING ANCHORS
CAPACITY BUILDING

INSUFFICIENT: fails to address the minimum required elements	**MEETS REQUIREMENTS**: addresses the minimum required elements	**EXCEEDS REQUIREMENTS**: addresses all elements including expanded or optional items
Did not discuss training/capacity building activities for the task force membership or key stakeholders	Discussed training/capacity building activities for the task force membership or key stakeholders	Provided detailed information on training/capacity building activities related to the SPF for the task force membership or key stakeholders
Did not address any internal or external partnerships	Addressed internal or external partnerships established and described how these would increase capacity to implement EBPs selected with some reference to the priority consequence, consumption pattern(s) and community level risk/protective factor	Addressed internal or external partnerships established and described how these would increase capacity to implement EBPs selected and described them as they related specifically to the specific priorities selected
Did not address any identified gaps in resources	Identified gaps in resources to address the priority consequence, consumption pattern(s) and community level risk/protective factors and described a plan to address them.	Identified gaps in resources to address the priority consequence, consumption pattern(s) and community level risk/protective factors and described a plan to address them AND provided a timeline for these activities.
Did not address how the assessment of community readiness impacted the mobilization and capacity building plan	Described how the assessment of community readiness impacted the mobilization and capacity building plan	Described how the assessment of community readiness impacted the mobilization and capacity building plan and how it is built into the plan

No communications strategy addressed	A communications strategy is described and is linked to the mobilization and capacity building plan	A communications strategy is described and is linked to the mobilization and capacity building plan AND it is linked to an objective of the capacity building plan
If sub-populations were identified, no discussion of sub-population(s) representation on task force/coalition and no outreach strategy proposed; sub-populations were not included in community readiness assessment and no plan to address any concerns related to level of readiness in sub-pop; and no assessment of programming needs of sub-populations.	Discussion of capacity building needs relevant to working with the identified sub-population(s) vulnerable to health disparities; **OR** identified an absence of sub-population.	Discussion of sub-population(s) representation on task force/coalition and an outreach strategy proposed (if representation is not proportional); sub-populations inclusion in community readiness assessment **AND** plans to address any concerns related to level of readiness in sub-pop are addressed.
No discussion of training and capacity building' developing or sustaining internal or external partnerships, addressing resource gaps or maintaining/refining communications strategies.	Training and capacity building, developing or sustaining internal or external partnerships, addressing resource gaps or maintaining/refining communications strategies is discussed, **AND** a plan is provided.	NA

In this section, sub-recipients are asked to identify specific areas that require strengthening or capacity building and plan by which to accomplish these goals.

1. Did the regional coalition describe needed training/capacity building activities for the regional or municipal membership or other key stakeholders.

   ☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

   Comments:

2. Did the regional coalition describe internal or external partnerships that would need to be established in order to either mobilize or increase capacity to implement evidence based practices, policies or programs (EBPs) to address the priority consequence, consumption pattern(s) and community level risk/protective factors.

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

3. Did the regional coalition describe resource gaps in the necessary additional human, financial or technological resources required to implement EBPs to address the priority consequence, consumption pattern(s) and community level risk/protective factors, and a plan to improve/increase these capacities.

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

4. Did the regional coalition discuss activities required to increase levels of community readiness to address the priority problem and associated risk or protective factors.

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

5. Did the regional coalition discuss any communications strategy (including media) developed to mobilize or engage the community in prevention efforts related to the community's priority consequence, consumption pattern(s) or identified risk or protective factors.

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

6. Did the regional coalition describe efforts to insure that sub-populations are proportionally represented on the task force/coalition? If not, is there a culturally appropriate/culturally relevant recruitment or outreach strategy to address engagement included within your community's mobilization and capacity building plan? Were sub-populations included in the assessment of community readiness? If yes, were any differences in the levels of readiness among sub-populations identified? If so, was a specific mobilization or capacity building strategy identified to address these differences and is it included in your community's mobilization and capacity building plan? As resources were assessed in Step 1, were the substance abuse prevention programming needs of

sub-populations identified as an area requiring additional capacity? If so, is this a component of your community's capacity building plan?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

7. SUSTAINABILITY – did the sub-recipient describe how key tasks associated with Step 2 might be sustained beyond the life of the RPTF?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

COMMUNITY NAME:

RI REGIONAL PREVENTION TASK FORCE: LOCAL STRATEGIC PLAN

GUIDANCE DOCUMENT REVIEW FORM/ reviewer initials

SECTION 3 – SPF STEP 3: PLANNING

Table 3 - SCORING ANCHORS
SPF STEP 3 - PLANNING

INSUFFICIENT: fails to address the minimum required elements	**MEETS REQUIREMENTS**: addresses the minimum required elements	**EXCEEDS REQUIREMENTS**: addresses all elements including expanded or optional items
No discussion of decision making process/structure	Discussion of decision making process/structure and, for final submission, appended minutes from TF meeting	Discussion of decision making process/structure and, for final submission, appended minutes from TF meeting
No discussion of who made the final decision	Discussion of who made the final decision	NA
No discussion of the specific EBP selected	Discussion of the specific EBP selected	NA
No justification for the specific EBP selected	Justification provided for the specific EBP selected	Justification provided for the specific EBP selected and linked back to all assessments conducted in Step 1
No discussion of fit/adaptation the specific EBP selected	Discussion of fit/adaptation the specific EBP selected	Discussion of fit/adaptation the specific EBP selected AND relates it back to capacity assessment findings
Did not address sustainability of EBP without RPTF funds	Addresses sustainability of EBP without RPTF funds	Articulates a clear plan to sustain EBP without RPTF funds
Did not describe available resources	Described available RPTF resources	Described both available RPTF resources **AND** other non-RPTF funds that might be leveraged
Did not address community readiness considerations	Addressed community readiness considerations as applied broadly (i.e., overall community level of readiness without specificity as to specific sectors)	Addressed community readiness as applied broadly **AND** also addressed levels of readiness across specific sectors

No discussion of how the EBPs selected, as part of a comprehensive approach, will achieve population level change with the identified priority problem	Discussion of how the EBPs selected, as part of a comprehensive approach, will achieve population level change with the identified priority risk factors and/or consumption patterns	Discussion of how the EBPs selected, as part of a comprehensive approach, will achieve population level change with the state identified priority risk/protective factors, consumption patterns and consequences
No logic model provided	A community logic model covering a priority problem and related risk/protective factors is provided	A community logic model covering a priority consequence, a priority consumption patterns and related risk/protective factors is provided and illustrates the theory of change
Did not address any of the following components: needs of sub-population and how they were incorporated; appropriateness of strategies proposed; processes implemented to solicit participation from sub-populations in development of plan; training/professional development requirements for staff or sub-contractors; and, mechanisms for assessing provider cultural competence; **OR** didn't address an absence of an identified sub-population	Addressed the following components: needs of sub-population and how they were incorporated; appropriateness of strategies proposed; processes implemented to solicit participation from sub-populations in development of plan; training/professional development requirements for staff or sub-contractors; and, mechanisms for assessing provider cultural competence; **OR** addressed an absence of an identified sub-population	Addressed everything contained in the prior column **AND** provided detailed analysis of those findings related to the proposed approach.
Did not address how applying the prior steps of the SPF can be used to identify effective strategies/EBPs to meet community need or how a strategic plan might be prepared for the community post-SPF funding	Addressed how applying the prior steps of the SPF could be used to identify effective strategies/EBPs to meet community need; **AND** how a strategic plan might be prepared for the community post-SPF funding	Proposed a plan to apply the prior steps of the SPF to identify effective strategies/EBPs to meet community need; **AND** a process to continue strategic planning in the community post-SPF funding

In this section, the regional coalition should specify which priority problem, consumption pattern(s) and risk or protective factors have been selected, and, which specific strategies/evidence-based practices, policies or programs (EBPs) have been selected to address the community's needs. A community level logic model which provides a

graphic depiction of each of these elements must also be provided. Tow what extend did the sub-recipient describe:

PROPOSED APPROACH (SELECTION OF EVIDENCE BASED PRACTICES, POLICIES, AND PROGRAMS)

1. Did the regional coalition describe the process/structure through which a final decision on the proposed approach was made (e.g., majority vote of the task force, recommendation from Sub-Committee to the Executive Committee, recommendation of Sub-Committee to the entire task force)

   ☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

   Comments:

2. Did the regional coalition describe who made the final decision (e.g., the entire task force, Executive Committee, Sub-Committee with approval from full task force)?

   ☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

   Comments:

3. Did the regional coalition describe the EBP(s) selected and

   a. Fit/adaptation considerations
   b. Potential for sustainability of intended outcomes without additional funds at the end of the 3-year award
   c. Available resources including financial resources (cost of EBP), and
   d. A description of the selected approach will result in population level change at the community

   ☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

   Comments:

4. A community level logic model depicting the priority problem, consumption pattern(s) (as applicable), associated risk or protective factor(s), and the strategies/EBPs selected to address them

   ☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

   Comments:

5. Cultural Competency and Sub-Populations Vulnerable to Health Disparities
   Did the plan explain how were the needs of sub-populations vulnerable to health disparities incorporated into the strategic plan? The process used to determine if the EBPs selected were culturally relevant and appropriate? Identification of any processes, either formal or informal, to solicit participate from sub-populations in the preparation of the plan and/or selection of EBPs? Inclusion of any training/professional development requirements related to cultural competency for any staff or sub-contractors

   ☐ Insufficient ☐ Meets Requirements ☐ Exceeds Requirements

   Comments:

6. SUSTAINABILITY
   Did the regional coalition describe how key tasks associated with Step 3 might be sustained beyond the life of the RPTF. Including: Applying the prior steps of the SPF to identifying effective strategies/EBPs to meet community need, and preparation of a strategic plan for the community.

   ☐ Insufficient ☐ Meets Requirements ☐ Exceeds Requirements

   Comments:

COMMUNITY NAME:

RI REGIONAL PREVENTION TASK FORCE: LOCAL STRATEGIC PLAN

GUIDANCE DOCUMENT REVIEW FORM/ reviewer initials

Table 5 - SCORING ANCHORS
SPF STEP 4 IMPLEMENTATION

INSUFFICIENT: fails to address the minimum required elements	**MEETS REQUIREMENTS**: addresses the minimum required elements	**EXCEEDS REQUIREMENTS**: addresses all elements including expanded or optional items
No task and timeline is provided.	A task and timeline is provided in the template format.	The task and timeline is provided in the template format; **AND** provides detailed information for each quarter for the duration of the initiative.
No implementation narrative is provided	An implementation narrative briefly describing key activities, responsible party(ies) and products produced is provided	A detailed implementation narrative describing all key activities for the duration of the initiative is provided.
No description of strategies employed to ensure cultural competency in staffing and sub-contracting and no process used to assess cultural relevance and cultural appropriateness of EBPs during implementation.	A description of strategies employed to ensure cultural competency in staffing and subcontracting and the process used to assess cultural relevance and cultural appropriateness of EBPs during implementation is provided; **OR** an absence of an identified sub-population is addressed.	**Multiple** strategies are employed to ensure cultural competency in staffing and subcontracting and the process used to assess cultural relevance and cultural appropriateness of EBPs during implementation is provided.
No description of how key tasks associated with Step 4 could be sustained.	Describes how lessons learned from Step 3 could inform a task and timeline for future ventures, AND how EBPs might be continued	A detailed description of lessons learned from Step 3 and how they inform a task and timeline for future ventures is provide, AND a detailed description of how EBPs might be continued and by whom is provided.

In this section, regional coalition are asked to provide details on their implementation activities, including the submission of a detailed task and timeline and an implementation narrative.

1. Did the implementation plan provide a sufficiently detailed **timeline**?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

COMMUNITY NAME: _____

RI REGIONAL PREVENTION TASK FORCE: LOCAL STRATEGIC PLAN GUIDANCE DOCUMENT REVIEW FORM/ reviewer initials _____

2. Did the implementation plan contain an implementation narrative briefly describing the key activities, responsible party(ies) and any products to be produced (including any any sub-contractors or community partners)

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

3. Revised budget forms and a narrative to include a 5 year overall budget and annualized budgets for the each of the years of the award.
NOTE: Not required for this submission; will be submitted upon plan approval.

4. Did the implementation plan contain strategies to insure cultural competency in staffing and sub-contracting

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

5. Did the implementation plan include discussion of the process used to assess cultural relevance and cultural appropriateness of EBPs during the implementation phase?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

6. Sustainability: Did the implementation plan how the lessons learned from Step 3 can help to develop a task and timeline for future ventures; and describe how the evidence based practices, policies or programs might be continued by either internal or external coalitions partners?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

COMMUNITY NAME:

RI REGIONAL PREVENTION TASK FORCE: LOCAL STRATEGIC PLAN

GUIDANCE DOCUMENT REVIEW FORM/ reviewer initials

Table 5 - SCORING ANCHORS
SPF STEP 5 - EVALUATION

INSUFFICIENT: fails to address the minimum required elements	**MEETS REQUIREMENTS**: addresses the minimum required elements	**EXCEEDS REQUIREMENTS**: addresses all elements including expanded or optional items
No mention of a plan to monitor implementation.	A monitoring plan describing how key implementation activities will be tracked is included.	A monitoring plan which describes
Administration of the RI Student Survey is not mentioned	Administration of the RI Student Survey in 2018 and 2020 is mentioned	Administration of the RI Student Survey in 2018 and 2020 is mentioned, **AND** is included for each of these years in the Task and Timeline.
Not required/not required	Not required/not required	Additional collection of qualitative or quantitative evaluation data is described.
Not required/not required	Not required/not required	Mentioned use of fidelity tools and a plan for their administration
Not required/no penalty	Not required/no penalty	Mentioned use of pre and post- tests associated with the selected EBP

In this section, sub-recipients are supposed to describe the monitoring and evaluation of their RPTF efforts.

1. Did the evaluation plan include a plan to monitor the implementation, including provision of services by sub-contractors (if applicable)

   ☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

   Comments:

2. A brief narrative including the following evaluation tasks:

   a. Administration of the Rhode Island Student Survey
   b. Additional collection of either qualitative or quantitative data
   c. Use of fidelity tools associated with the evidence based practices, policies or programs (if applicable)/optional
   d. Any administration of pre or post- tests associated with evidence based practices, policies or programs/optional

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

3. Cultural competency and sub-populations vulnerable to health disparities: Did the evaluation plan insure that culturally appropriate and relevant measures are being utilized for monitoring and evaluation? Did the evaluation plan describe a process for monitoring the cultural competence of community level activities?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

4. Sustainability: Did the evaluation plan describe how monitoring of program activities, including evidence based practices, policies or programs might be sustained?

☐Insufficient ☐Meets Requirements ☐ Exceeds Requirements

Comments:

General Notes to Reviewers:

The Regional Prevention Task Force (RPTF) coalitions were provided with a document entitled "Rhode Island Regional Prevention Task Force: A Guide to the Community Needs Assessment" (May 2017) which provided a number of quantitative data sources and tools for qualitative data collection. This was designed to assist them in the strategic planning process. The RPTF coalitions were instructed to complete a regional strategic plan using data collected during the needs assessment. to provide detailed information using the Strategic Prevention Framework process.

Appendix 5: BHDDH BUDGET TOOLS

- Example of Quarterly Payroll
- Attestation Form

Example of Quarterly Payroll

	A	B	C	D	E	F	G	H	I	J
1										
2										
3	**Provider:**	Name of your organizatio			**Approval signature:**					
4										
5										
6	**Contract:**	Regional Task Force			**Date submitted:**		42926			
7										
8										
9	**Month Ending**	**Employee Last Name**	**Employee First name**	**Title**	**Hours to Contract**	**Hourly Wage**	**Total**	**Total Fringe**	**Total**	**Fringe Percent**
10	42766	Sample A	Sample B	Project Director	0	0	=E10*F10	0	0	=H10/G10
11	42794	Sample C	Sample D	Project Coordinator	0	0	=E11*F11	0	0	=H11/G11
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23					0	0	=E23*F23	0	=G23+H23	=H23/I23
24					0	0	=E24*F24	0	=G24+H24	=H24/I24
25					0	0	=E25*F25	0	=G25+H25	=H25/I25
26					0	0	=E26*F26	0	=G26+H26	=H26/I26
27					0	0	=E27*F27	0	=G27+H27	=H27/I27
28					0	0	=E28*F28	0	=G28+H28	=H28/I28
29					=SUM(E10:E28)		=SUM(G10:G28	=SUM(H10:H2	=SUM(I10:I28	=H29/I29
30										
31	Page _____ of _____									

Attestation of Submitted Costs

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

Provider: _____

Service period: _____

Contract Description: _____

- **Salary** – Signature below certifies that the salaries charged in this invoice are for actual costs for services provided under this contract and are only for employees originally contained within the approved budget.

_____	_____	_____	_____
Printed Name	Signature	Date	N/A

- **Fringe** - Signature below certifies that the fringe charged in this invoice are for actual costs for services provided under this contract and are only for employees originally contained within the approved budget.

_____	_____	_____	_____
Printed Name	Signature	Date	N/A

- **Postage/Office Supplies** – Signature below certifies that the purchase of postage/office supplies are directly related to this contract. If invoiced amount is a percentage of the overall agency cost for this month then the amount invoiced does not exceed the percentage of the overall agency budget this contract represents.

_____	_____	_____	_____
Printed Name	Signature	Date	N/A

- **Telephone/internet/cable** - Signature below certifies that the purchase of telephone/internet/cable are directly related to this contract. If invoiced amount is a percentage of the overall agency cost for this month then the amount invoiced does not exceed the percentage of the overall agency budget this contract represents.

_____	_____	_____	_____
Printed Name	Signature	Date	N/A

- **Information System -** Signature below certifies that the purchase of telephone/internet/cable are directly related to this contract. If invoiced amount is a percentage of the overall agency cost for this month then the amount invoiced does not exceed the percentage of the overall agency budget this contract represents.

_____	_____	_____	_____
Printed Name	Signature	Date	N/A

- **Heat and Utilities -** Signature below certifies that the purchase of telephone/internet/cable are directly related to this contract. If invoiced amount is a percentage of the overall agency cost for this month then the amount invoiced does not exceed the percentage of the overall agency budget this contract represents.

_____	_____	_____	_____
Printed Name	Signature	Date	N/A