Rhode Island ORIENTATION GUIDE for Regional Prevention Task Forces

DEPARTMENT OF BEHAVIORAL HEALTHCARE DEVELOPMENTAL DISABILITIES & HOSPITALS
BHDDH

RIPRC

STATE OF RHODE ISLAND

Department of Behavioral Healthcare, Developmental Disabilities & Hospitals
BEHAVIORAL HEALTHCARE SERVICES
14 Harrington Road
Cranston, RI 02920

TEL: (401) 462-3201
FAX: (401) 462-3204

February 23, 2024

Dear Members of the Prevention Community:

On behalf of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH), we are pleased to welcome you to the updated Rhode Island Orientation Guide for Regional Prevention Task Force coalitions. In 2018, and in partnership with the Rhode Island Prevention Resource Center, we created this guide to help orient municipal and regional coalition coordinators, coalition members, and other preventionists to our state's substance use prevention infrastructure. 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. The guide includes an overview of prevention in Rhode Island as well as coalition operations & functioning, coalition activities, and other resources that you may find helpful.

Since 1987, BHDDH has been committed to substance misuse prevention and mental health promotion as part of its role as the single state authority of substance use in Rhode Island. 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 in order to reduce negative outcomes associated with behavioral health problems.

We hope that this Guide will continue to serve to be a valuable resource for Rhode Island regional and municipal coalitions and their partners statewide.

Sincerely,

Candace Rodgers, MPH, MCHES©
Unit Administrator for Prevention and Recovery Services, Division of Behavioral Health
RI Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH)

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 & 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 BHDDH. All or part of the 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.

CONTENTS

INTRODUCTION AND PURPOSE

INTRODUCTION

The Rhode Island Department of Behavioral Health, Developmental Disabilities & 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 Prevention 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 responsiveness 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 Misuse 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 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 and links to key websites and references.

FOR MORE INFORMATION:

For information about the behavioral health system in Rhode Island, please contact the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH):

Phone: 401-462-0644

Web: 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 misuse prevention in the U.S.; an overview of the Strategic Prevention Framework; and cultural responsiveness 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 enacting and enforcing laws that restrict youth access to alcohol, and assuring that all pregnant women have access to prenatal care.

Behavioral health issues include:

- Substance misuse
- Alcohol and drug addiction
- Mental health disorders 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 health disorders and substance use disorders, and recovery support.

The public health approach and the Behavioral Health Continuum of Care co-exist and both influence the field of prevention in behavioral health.

Source: SAMHSA, SAPST, Version 9, February 2018 - Reference #HHSS283201200024I/HHSS283420002T

PUBLIC HEALTH APPROACH

A commonly used definition of ***public health*** comes from the National Academies of Sciences, Engineering, and Medicine (previously referred to as the Institute of Medicine (IOM): "It is what we, as a society, do collectively to assure the conditions for people to be healthy."

PUBLIC HEALTH APPROACH: KEY CHARACTERISTICS

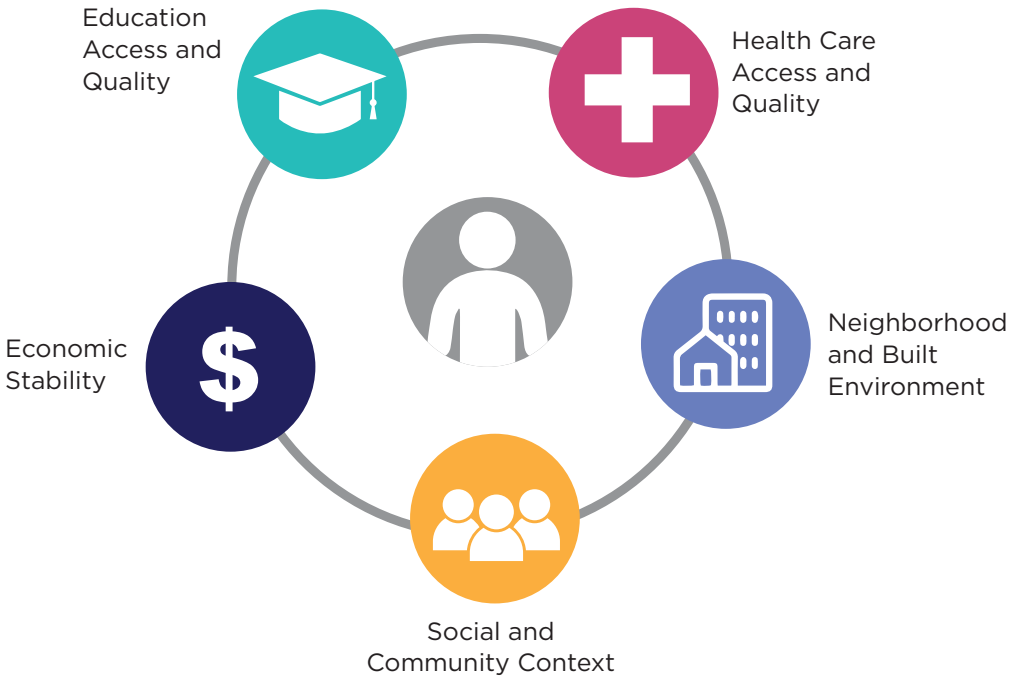
- **Promotion and prevention** – The focus is on promoting wellness and preventing problems.
- **Population-based** – The focus is not on one individual but on the population that is affected and that is at risk.
- **Risk and protective factors** – These are the factors that influence the problem.
- **Multiple contexts** – Understands that the individual is influenced by different environments, such as the family, neighborhood, school, community, culture, and society.
- **Developmental perspective** – Considers 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 recognizes that the social determinants of health have a major impact on people's health, well-being and quality of life.

Source: SAMHSA, SAPST, Version 9, Information Sheet 1.11, February 2018 - Reference #HHSS283201200024I/ HHSS28342002T

The **social determinants of health** are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. They can be grouped into 5 domains as shown in the graphic below:

SOCIAL DETERMINANTS OF HEALTH



THE PUBLIC HEALTH APPROACH TO DEVELOPING PREVENTION INTERVENTION AND STRATEGIES ASKS THE FOLLOWING QUESTIONS...

WHAT?	Who?	When?	Where?	Why?	How?
What substance misuse and other behavioral health problems need to be addressed?	Who will the interventions focus on—the entire population or a specific population group?	When in the lifespan—at what specific developmental stage—is the population group that the interventions focus on? (e.g., adolescence, young adulthood)	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 are these problems occurring? This refers to the risk and protective factors that contribute to the problems.	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: SAMHSA, SAPST, Version 9, February 2018 - Reference #HHSS283201200024I/HHSS28342002T

THE BEHAVIORAL HEALTH CONTINUUM OF CARE

The Behavioral Health 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 use

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, inpatient treatment, medication-assisted treatment).

Maintenance includes interventions that focus on participation in long-term treatment to reduce relapse/reoccurrence, and aftercare including rehabilitation and recovery support.

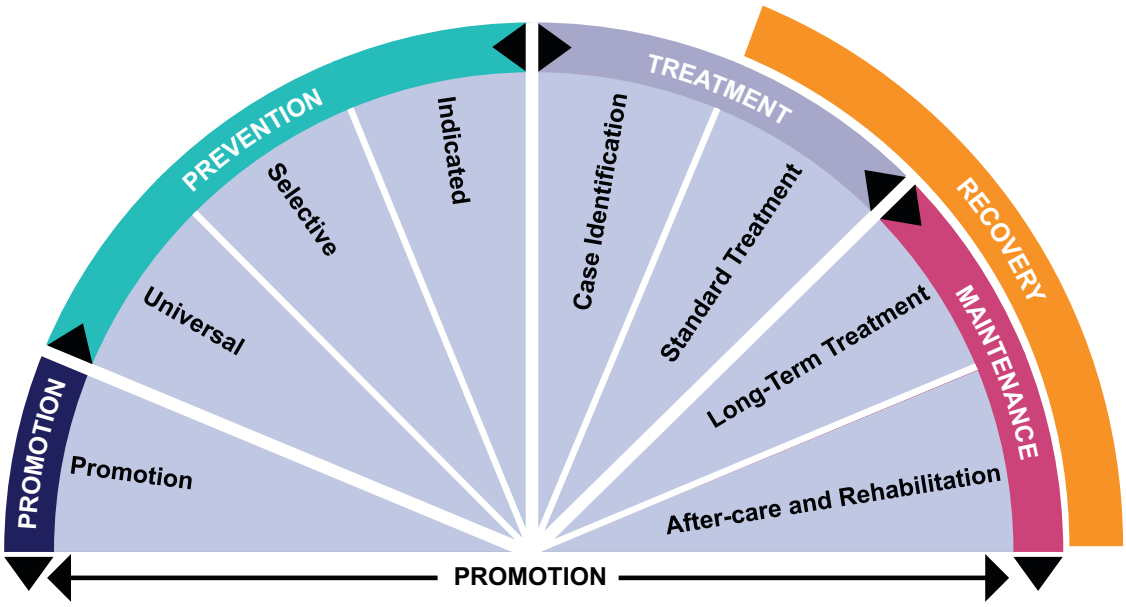
Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

**Formerly known as the Institute of Medicine (IOM) Continuum of Care (As of 2015, the IOM is now referred to as the National Academies of Sciences, Engineering, and Medicine).*

Source: SAMHSA, SAPST, Version 9, February 2018 - Reference #HHSS283201200024I/HHSS283342002T

THE ULTIMATE GOAL OF PREVENTION ACTIVITIES IS WELLNESS

BEHAVIORAL HEALTH CONTINUUM



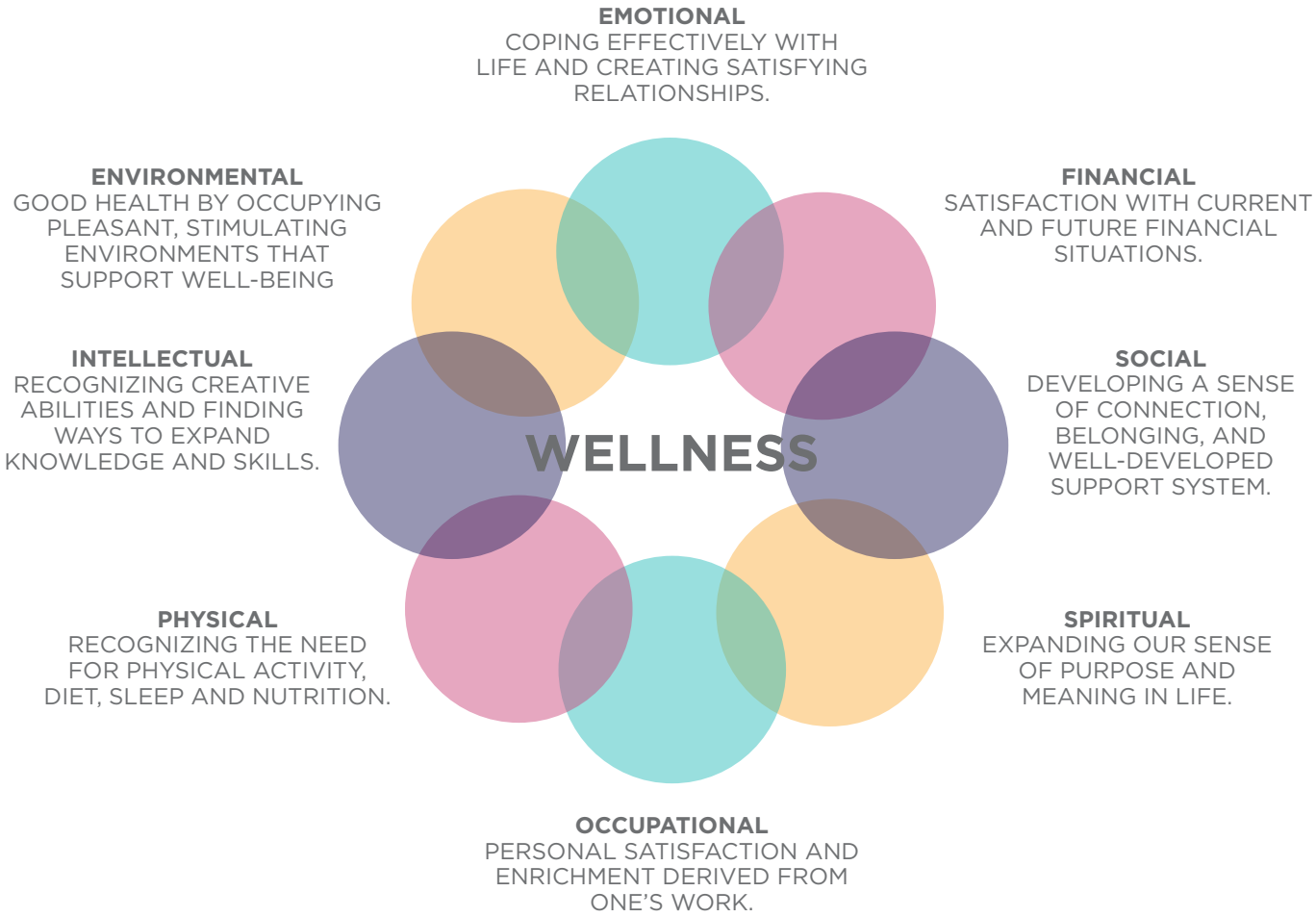
Source: SAMHSA, SAPST, Version 9, February 2018 - Reference #HHSS283201200024I/HHSS283342002T

Wellness is a conscious, deliberate process that requires awareness of—and making choices for—a more satisfying 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:



Source: Adapted from Swarbrick, M., Psychiatric Rehabilitation Journal, A Wellness Approach, 2006

A BRIEF HISTORY OF SUBSTANCE MISUSE PREVENTION STRATEGIES

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 counterculture. By the end of the decade drug use was considered a national epidemic.	Scare tactics through films and speakers; information about substance use through films and speakers
1970s	Alcohol and drug misuse were recognized as major public health problems. The 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 Drugs effort, encouraged youth to resist peer pressure by saying "no." Partnerships developed as the public became increasingly involved in addressing the problems of substance misuse.	Parent-formed organizations to combat drug use; social skills curricula, refusal skills 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 use. The value of professionalism and training in this area grew. Community coalitions received funding to address alcohol and drug misuse 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 misuse and mental health disorders/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 – PRES-ENT	Greater emphasis is placed on prevention and treatment for everyone. Behavioral health was integrated with primary care under the Affordable Care Act of 2010. Increased prescription of opioid medications resulting from misinformation spread by pharmaceutical companies starting in the late 90s led to widespread opioid misuse, and in 2017, the opioid crisis was declared a public health emergency. The COVID-19 pandemic and spread of highly potent synthetic opioids containing fentanyl have contributed to the most significant substance use and overdose epidemic ever faced in the U.S.	Use of evidence-based practices; strategic planning process; improved access to health insurance with better benefits for mental health and substance misuse treatment and support. Expansion of harm reduction approaches* to prevent death, injury, disease, overdose, and other harms associated with substance use/misuse and mitigate the impacts of the overdose epidemic.

**Harm reduction is an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services.*

Sources:

SAMHSA, SAPST, Version 9, Information Sheet 1.2, February 2018 - Reference #HHSS283201200024I/HHSS28342002T

U.S. Department of Health and Human Services, Opioid Facts and Statistics, December 2022

SAMHSA, Harm Reduction, August 2022

PREVENTION THEORIES AND STRATEGIES

RISK AND PROTECTIVE FACTOR THEORY AND SOCIO-ECOLOGICAL MODEL

Many factors influence the likelihood that an individual will develop a substance use disorder 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.

The **Socio-Ecological Model** is a multi-level framework that considers the different contexts in which risk and protective factors exist, including the Individual level, the Relationship level, the Community level and the Societal level, as shown in the graphic below. The model allows us to look at how the different levels/contexts interact with each other and choose prevention strategies that operate at multiple levels for the greatest impact.

Source: Center for Substance Abuse Prevention, SAMHSA, A Guide to SAMHSA's Strategic Prevention Framework, 2019

Here are some examples of risk and protective factors existing at the different levels/contexts.

- *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.

- *Relationship level:* Examples of Relationship 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 after school activities.
- *Societal level:* Examples of Societal 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, and transgender youth.

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

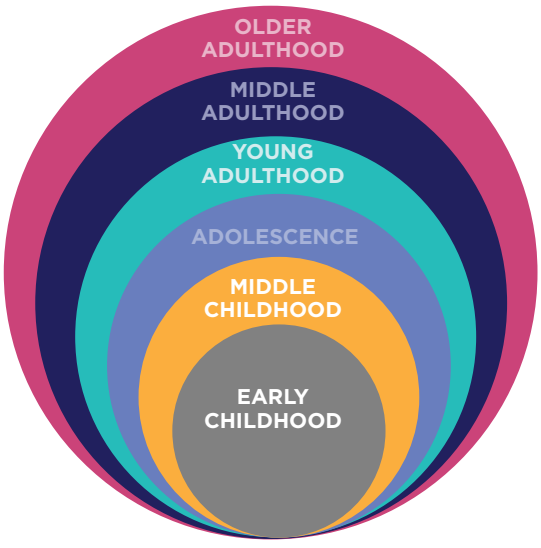
Source: SAMHSA, SAPST, Version 9, Information Sheet 1.8, February 2018 - Reference #HHSS283201200024I/ HHSS28342002T

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 for people with disabilities.



Source: SAMHSA, SAPST, Version 9, Information Sheet 1.10, February 2018 - Reference #HHSS283201200024I/ HHSS28342002T

- Understanding the developmental perspective is important to substance misuse prevention because:
  - » Interventions should be appropriate for the specific developmental stage of the population that they focus on.
  - » 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 misuse and other behavioral health problems when they have experienced untreated, unresolved trauma.

Source: SAMHSA, SAPST, Version 9, Information Sheet 1.10, February 2018 - Reference #HHSS283201200024I/ HHSS283420002T

The **Social Development Model (SDM)**, developed by Catalano and Hawkins (1996), looks at the factors and contexts that contribute to the development of prosocial and antisocial behavior in children and adolescents. The SDM suggests that multilevel developmental influences, such as key contexts (family, school, and community), the child's social and emotional skills, and the parenting skills of the child's caregivers, as well as the strength and quality of the child's social attachments, all jointly influence whether or not the young person engages in behaviors such as drug use or delinquency.

Source: Catalano, R. F., & Hawkins, J. D., Delinquency and Crime: Current Theories, The Social Development Model: A Theory of Antisocial Behavior, Cambridge University Press, 1996

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.

The five stages of change are:

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

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

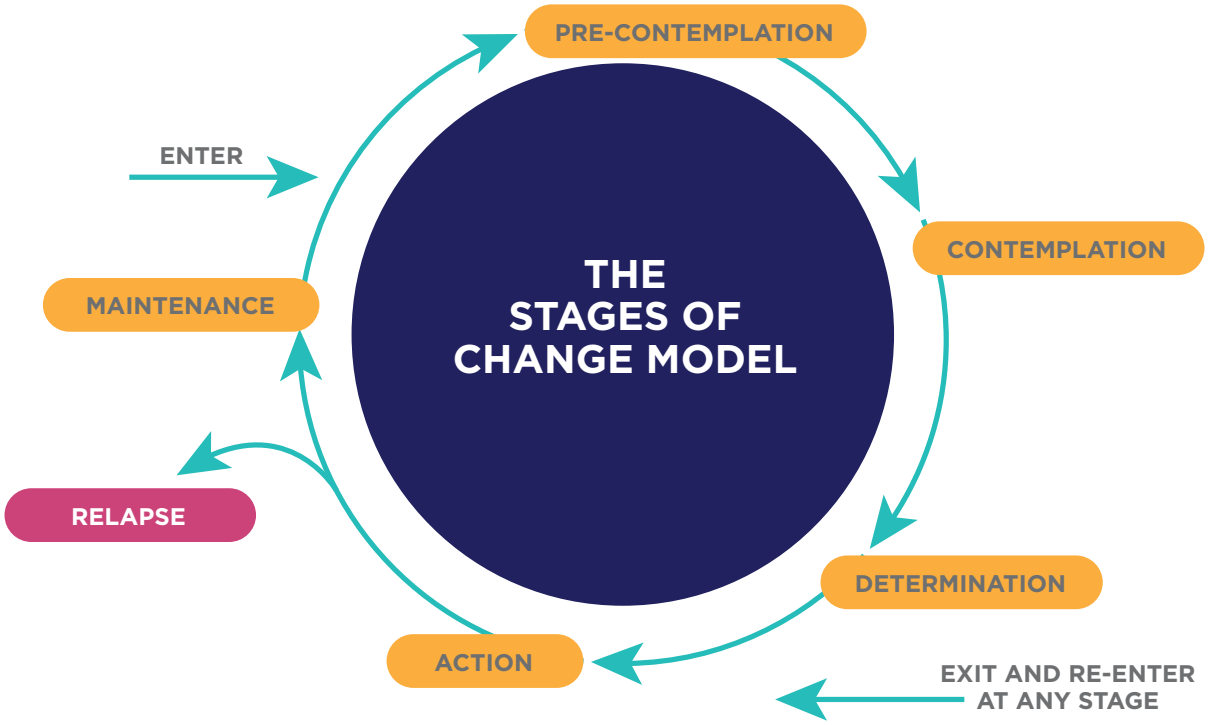
In the process of changing behavior, people cycle between stages, rather than move through the stages in a linear way. People can learn from relapse/reoccurrence about what to do to sustain a change.

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/Determination: 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.



Source: Johnny Holland, Stages of Change Model by Prochaska & DiClemente, 2011

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

Relapse/Reoccurrence: 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 (you may also see "recurrence" used).

Source: Rhode Island Behavioral Health Peer Recovery Specialist Curriculum - Day 5, 2015

BROAD TYPES OF PREVENTION STRATEGIES

Some types of prevention strategies focus on the individual, 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 focus on young people, parents, 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** involve 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, social media, as well as in music, movies and magazines, glamorize drug, alcohol, and tobacco misuse. Yet, the media can be used to encourage positive behaviors, as well.

Source: SAMHSA, SAPST, Version 9, Information Sheet 4.1, February 2018 - Reference #HHSS283201200024I/ HHSS28342002T

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.

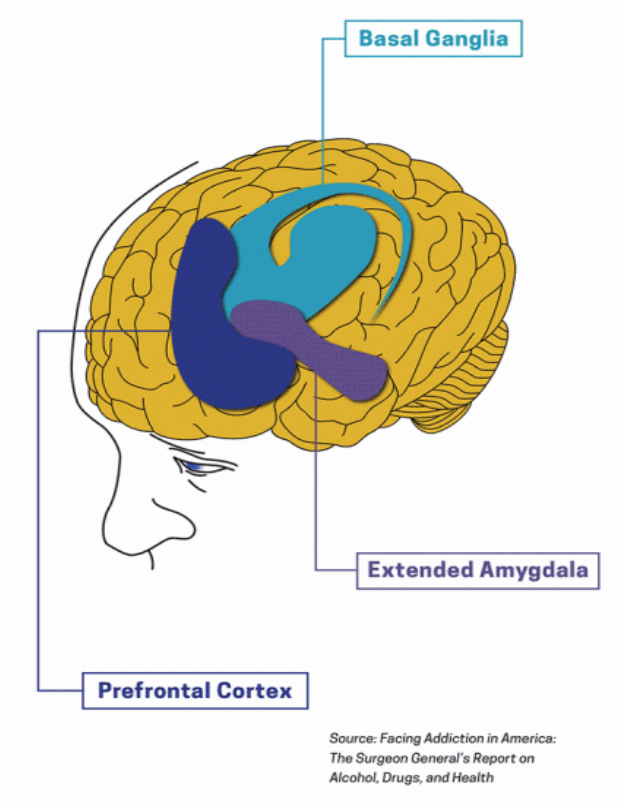
Strategies focused on changing the community environmental contexts that influence individual behavior include those that:

- **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). In prevention efforts, this strategy can also be "turned around" to 'reduce access/enhance barriers', for example, reducing access and enhancing barriers to purchasing alcohol, tobacco products or marijuana for people under 21.
- **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 desired 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: CADCA, The Coalition Impact: Environmental Prevention Strategies, 2010

ALCOHOL, TOBACCO & OTHER DRUGS – EFFECTS ON THE BRAIN

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:



Source: Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health

- The ***basal ganglia***, which play an important role in positive forms of motivation, including the pleasurable effects of healthy activities like eating, socializing, and sex, and are also involved in the formation of habits and routines. These areas form a key node of what is sometimes called the brain's "reward circuit." Drugs over-activate this circuit and produce the euphoria of the drug high. However, with repeated exposure, the circuit adapts to the presence of the drug, diminishing its sensitivity and making it hard to feel pleasure from anything besides the drug.
- The ***extended amygdala*** plays a role in stressful feelings like anxiety, irritability, and unease, which characterize withdrawal after the drug high fades and thus motivates the person to seek the drug again. This circuit becomes increasingly sensitive with increased drug use. Over time, a person with substance use disorder uses drugs to get temporary relief from this discomfort rather than to get high.
- The ***prefrontal cortex*** powers the ability to think, plan, solve problems, make decisions, and exert self-control over impulses. This is also the last part of the brain to mature, making teens most vulnerable. Shifting balance between this circuit and the circuits of the basal ganglia and extended amygdala make a person with substance use disorder seek the drug compulsively with reduced impulse control.

Some drugs like opioids also disrupt other parts of the brain, such as the brain stem, which controls basic functions critical to life, including heart rate, breathing, and sleeping. This interference explains how overdoses can cause depressed breathing and death.

NIDA
NATIONAL INSTITUTE ON DRUG ABUSE

Commonly Abused Drugs

Visit NIDA at www.drugabuse.gov

Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**
Tobacco		
Nicotine	Found in cigarettes, cigars, bidis, and smokeless tobacco (snuff, spit tobacco, chew)	Not scheduled/smoked, snorted, chewed
Alcohol		
Alcohol (ethyl alcohol)	Found in liquor, beer, and wine	Not scheduled/swallowed
Cannabinoids		
Marijuana	Blunt, dope, ganja, grass, herb, joint, bud, Mary Jane, pot, reefer, green, trees, smoke, sinsemilla, skunk, weed	I/smoked, swallowed
Hashish	Boom, gangster, hash, hash oil, hemp	I/smoked, swallowed
Opioids		
Heroin	*Diacetylmorphine:* smack, horse, brown sugar, dope, H, junk, skag, skunk, white horse, China white; cheese (with OTC cold medicine and antihistamine)	I/injected, smoked, snorted
Opium	*Laudanum, paregoric:* big O, black stuff, block, gum, hop	II, III, V/swallowed, smoked
Stimulants		
Cocaine	*Cocaine hydrochloride:* blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II/snorted, smoked, injected
Amphetamine	*Biphetamine, Dexedrine:* bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II/swallowed, snorted, smoked, injected
Methamphetamine	*Desoxyn:* meth, ice, crank, chalk, crystal, fire, glass, go fast, speed	II/swallowed, snorted, smoked, injected
Club Drugs		
MDMA (methylenedioxymethamphetamine)	Ecstasy, Adam, clarity, Eve, lover's speed, peace, uppers	I/swallowed, snorted, injected
Flunitrazepam***	*Rohypnol:* forget-me pill, Mexican Valium, R2, roach, Roche, roofies, roofinol, rope, rophies	IV/swallowed, snorted
GHB***	*Gamma-hydroxybutyrate:* G, Georgia home boy, grievous bodily harm, liquid ecstasy, soap, scoop, goop, liquid X	I/swallowed
Dissociative Drugs		
Ketamine	*Ketalar SV:* cat Valium, K, Special K, vitamin K	III/injected, snorted, smoked
PCP and analogs	*Phencyclidine:* angel dust, boat, hog, love boat, peace pill	I, II/swallowed, smoked, injected
Salvia divinorum	Salvia, Shepherdess's Herb, Maria Pastora, magic mint, Sally-D	Not scheduled/chewed, swallowed, smoked
Dextromethorphan (DXM)	Found in some cough and cold medications: Robotripping, Robo, Triple C	Not scheduled/swallowed
Hallucinogens		
LSD	*Lysergic acid diethylamide:* acid, blotter, cubes, microdot, yellow sunshine, blue heaven	I/swallowed, absorbed through mouth tissues
Mescaline	Buttons, cactus, mesc, peyote	I/swallowed, smoked
Psilocybin	Magic mushrooms, purple passion, shrooms, little smoke	I/swallowed
Other Compounds		
Anabolic steroids	*Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise:* roids, juice, gym candy, pumpers	III/injected, swallowed, applied to skin
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

Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**
Prescription Medications		
CNS Depressants Stimulants Opioid Pain Relievers	For more information on prescription medications, please visit http://www.nida.nih.gov/DrugPages/PrescripDrugsChart.html.	

National Institutes of Health
U.S. Department of Health and Human Services
NIH... Turning Discovery Into Health

Substances: Category and Name	*Acute Effects*/Health Risks
Tobacco	
Nicotine	*Increased blood pressure and heart rate*/chronic lung disease; cardiovascular disease; stroke; cancers of the mouth, pharynx, larynx, esophagus, stomach, pancreas, cervix, kidney, bladder, and acute myeloid leukemia; adverse pregnancy outcomes; addiction
Alcohol	
Alcohol (ethyl alcohol)	*In low doses, euphoria, mild stimulation, relaxation, lowered inhibitions; in higher doses, drowsiness, slurred speech, nausea, emotional volatility, loss of coordination, visual distortions, impaired memory, sexual dysfunction, loss of consciousness/*increased risk of injuries, violence, fetal damage (in pregnant women); depression; neurologic deficits; hypertension; liver and heart disease; addiction; fatal overdose
Cannabinoids	
Marijuana Hashish	*Euphoria; relaxation; slowed reaction time; distorted sensory perception; impaired balance and coordination; increased heart rate and appetite; impaired learning, memory; anxiety; panic attacks; psychosis/*cough; frequent respiratory infections; possible mental health decline; addiction
Opioids	
Heroin Opium	*Euphoria; drowsiness; impaired coordination; dizziness; confusion; nausea; sedation; feeling of heaviness in the body; slowed or arrested breathing/*constipation; endocarditis; hepatitis; HIV; addiction; fatal overdose
Stimulants	
Cocaine Amphetamine Methamphetamine	*Increased heart rate, blood pressure, body temperature, metabolism; feelings of exhilaration; increased energy, mental alertness; tremors; reduced appetite; irritability; anxiety; panic; paranoia; violent behavior; psychosis/*weight loss; insomnia; cardiac or cardiovascular complications; stroke; seizures; addiction **Also, for cocaine**—nasal damage from snorting **Also, for methamphetamine**—severe dental problems
Club Drugs	
MDMA (methylenedioxymethamphetamine) Flunitrazepam*** GHB***	***MDMA****—mild hallucinogenic effects; increased tactile sensitivity, empathic feelings; lowered inhibition; anxiety; chills; sweating; teeth clenching; muscle cramping/*sleep disturbances; depression; impaired memory; hyperthermia; addiction ***Flunitrazepam****—sedation; muscle relaxation; confusion; memory loss; dizziness; impaired coordination/*addiction ***GHB****—drowsiness; nausea; headache; disorientation; loss of coordination; memory loss/*unconsciousness; seizures; coma
Dissociative Drugs	
Ketamine PCP and analogs Salvia divinorum Dextromethorphan (DXM)	*Feelings of being separate from one's body and environment; impaired motor function/*anxiety; tremors; numbness; memory loss; nausea ***Also, for ketamine****— analgesia; impaired memory; delirium; respiratory depression and arrest; death* ***Also, for PCP and analogs****—analgesia; psychosis; aggression; violence; slurred speech; loss of coordination; hallucinations* ***Also, for DXM****—euphoria; slurred speech; confusion; dizziness; distorted visual perceptions*
Hallucinogens	
LSD Mescaline Psilocybin	*Altered states of perception and feeling; hallucinations; nausea* ***Also, for LSD and mescaline****—increased body temperature, heart rate, blood pressure; loss of appetite; sweating; sleeplessness; numbness; dizziness; weakness; tremors; impulsive behavior; rapid shifts in emotion* ***Also, for LSD***—Flashbacks, Hallucinogen Persisting Perception Disorder ***Also, for psilocybin****—nervousness; paranoia; panic*
Other Compounds	
Anabolic steroids Inhalants	***Steroids****—no intoxication effects/*hypertension; blood clotting and cholesterol changes; liver cysts; 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 ***Inhalants*** *(varies by chemical)—stimulation; loss of inhibition; headache; nausea or vomiting; slurred speech; loss of motor coordination; wheezing/*cramps; muscle weakness; depression; memory impairment; damage to cardiovascular and nervous systems; unconsciousness; sudden death

Substances: Category and Name	*Acute Effects*/Health Risks
Prescription Medications	
CNS Depressants Stimulants Opioid Pain Relievers	

** 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.*

*** Some of the health risks are directly related to the route of drug administration. For example, injection drug use can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms.*

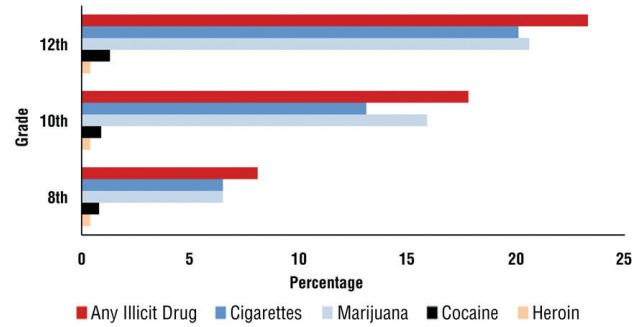
**** Associated with sexual assaults.*

Principles of Drug Addiction Treatment

More than three decades of scientific research show that treatment can help drug-addicted individuals stop drug use, avoid relapse and successfully recover their lives. Based on this research, 13 fundamental principles that characterize effective drug abuse treatment have been developed. These principles are detailed in *NIDA's Principles of Drug Addiction Treatment: A Research-Based Guide*. The guide also describes different types of science-based treatments and provides answers to commonly asked questions.

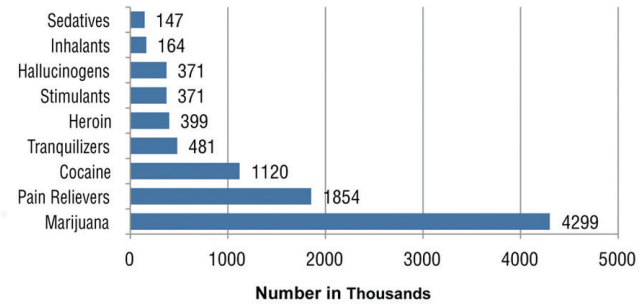
1. **Addiction is a complex but treatable disease that affects brain function and behavior.** Drugs alter the brain's structure and how it functions, resulting in changes that persist long after drug use has ceased. This may help explain why abusers are at risk for relapse even after long periods of abstinence.
2. **No single treatment is appropriate for everyone.** Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success.
3. **Treatment needs to be readily available.** Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible.
4. **Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.** To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems.
5. **Remaining in treatment for an adequate period of time is critical.** The appropriate duration for an individual depends on the type and degree of his or her problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment.
6. **Counseling—individual and/or group—and other behavioral therapies are the most commonly used forms of drug abuse treatment.** Behavioral therapies vary in their focus and may involve addressing a patient's motivations to change, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problemsolving skills, and facilitating better interpersonal relationships.
7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** For example, methadone and buprenorphine are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Also, for persons addicted to nicotine, a nicotine replacement product (nicotine patches or gum) or an oral medication (buproprion or varenicline), can be an effective component of treatment when part of a comprehensive behavioral treatment program.
8. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure it meets his or her changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation and/or social and legal services. For many patients, a continuing care approach provides the best results, with treatment intensity varying according to a person's changing needs.
9. **Many drug-addicted individuals also have other mental disorders.** Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.
10. **Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.** Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification.
11. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.
12. **Drug use during treatment must be monitored continuously, as lapses during treatment do occur.** Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.
13. **Treatment programs should assess patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, as well as provide targeted risk-reduction counseling to help patients modify or change behaviors that place them at risk of contracting or spreading infectious diseases.** Targeted counseling specifically focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Treatment providers should encourage and support HIV screening and inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations.

U.S. Teens Who Currently Use Illicit Drugs or Cigarettes (Past Month Use)



Source: University of Michigan, Monitoring the Future Study, 2009.

Dependence on or Abuse of Specific Illicit Drugs in Past Year Among Persons 12 or Older, 2009



Source: SAMHSA, 2009 NSDUH

NATIONAL INSTITUTE ON DRUG ABUSE
NIDA DRUGPUBS
RESEARCH DISSEMINATION CENTER

Order NIDA publications from DrugPubs:
1-877-643-2644 or 1-240-645-0228 (TTY/TDD)

Revised March 2011
Reprinted April 2012

For the most up-to-date and comprehensive information on commonly used drugs with the potential for misuse or addiction, please view the Commonly Used Drugs Charts on the National Institute on Drug Abuse (NIDA) website, as well as the 2020 edition of Drugs of Abuse: A DEA Resource Guide, from the U.S. Department of Justice Drug Enforcement Administration (DEA).

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.

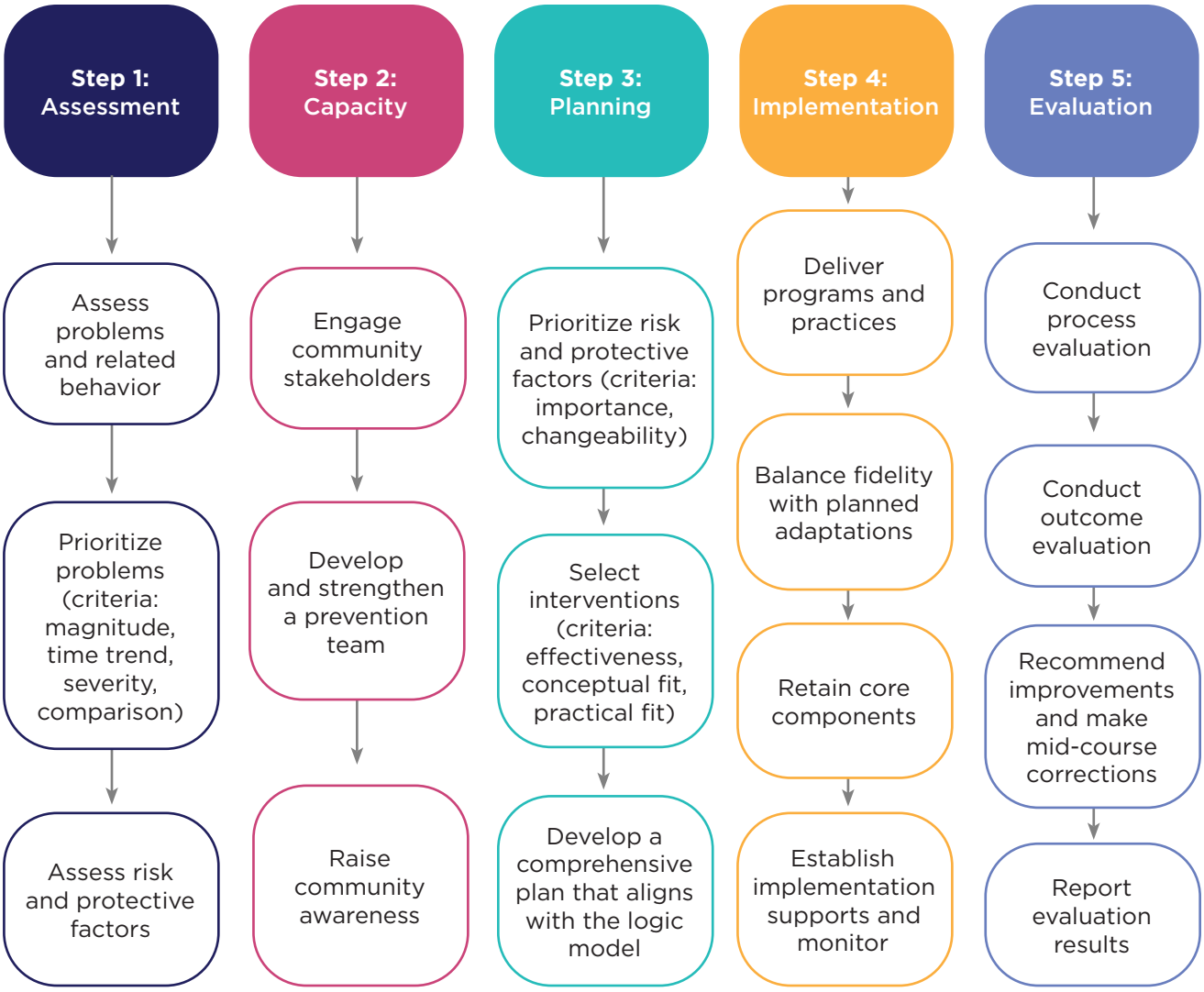
Source: SAMHSA, A Guide to SAMHSA's Strategic Prevention Framework, 2019

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 the 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



STEP 1: ASSESSMENT

Assessment helps communities better understand the extent and nature of behavioral health problems present in the community. 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?
- What are the risk and protective factors that influence problems and related behaviors in the community?

TYPES OF DATA

- **Quantitative data** indicates how often a behavior/event occurs or to what degree it exists.
    - It can provide the answers to "How many?" and "How often?"
    - It is typically described in "numbers."
    - It can be used to draw general conclusions about a population, such as the level of youth alcohol use in a community.

  Examples of methods for obtaining quantitative data include random sample surveys and archival sources.

- **Qualitative data** explains why people behave or feel the way they do.
    - It can help provide the answer to "Why/Why not?" or "What does it mean?"
    - It is usually described in "words."
    - It can be used to examine an issue or population in more depth to understand underlying issues, such as the way in which community norms contribute to the level of youth alcohol use.

  Examples of methods for obtaining qualitative data include key informant interviews and focus groups.

A "mixed methods" assessment approach that collects both quantitative and qualitative data provides a more in-depth understanding of the behavioral health problems being assessed.

DATA COLLECTION METHODS

Surveys: Standardized paper and pencil, online or phone questionnaires that ask pre-determined questions

Archival data: Data that have already been collected by an agency or organization and which are stored in their records or archives

Key Informant Interviews: Structured or unstructured, one-on-one directed conversations with key individuals or leaders in a community

Focus Groups: Structured interviews with small groups of like individuals using standardized questions, follow-up questions, and exploration of other related topics that arise.

PRIORITIZING PROBLEMS BASED ON ASSESSMENT RESULTS

The community assessment may reveal multiple problems and areas of need. To select which problems to focus prevention efforts on, consider the following:

- Magnitude: Which problem/behavior is most widespread in the community?
- Severity: Which problem/behavior is most serious?
- Trend: Which problem/behavior is getting worse or better?
- Changeability: Which problem/behavior are you most likely to influence with your prevention efforts?

ASSESSING CAPACITY FOR PREVENTION

Assess the community's capacity to address substance misuse:

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

A community needs to assess both the types and levels of resources that it has available to address identified behavioral health problems AND how ready the community is to take action to address the targeted behavioral health problem.

Types of resources to assess include:

- **Fiscal resources** – such as grants and donations, and tangible, physical resources such as meeting space and supplies
- **Human resources –** such as trained staff, consultants, volunteers, stakeholders, partners, local champions
- **Organizational resources** – such as vision and mission statements aligned with the prevention effort, and organizational policies, organizational budgets, and technology
- **Community resources** – such as previous efforts to address the problem, local policies and regulations, community awareness of the problem

COMMUNITY READINESS MODEL

The Tri-Ethnic Center Community Readiness Model identifies nine stages of readiness:

- **STAGE 1 – Community Tolerance/No Knowledge**: The community or leaders do not generally recognize that there is a problem. Community norms may encourage or tolerate the behavior in social contexts.
- **STAGE 2 – Denial:** There is some recognition by some members of the community that the behavior is a problem, but little or no recognition that it is a local problem.
- **STAGE 3 – Vague Awareness:** There is a general feeling among some in the community that there is a local problem and that something ought to be done, but there is little motivation to act.
- **STAGE 4 – Preplanning:** There is clear recognition by many that there is a local problem and something needs to be done. There may be a committee to address the problem, but no clear idea of how to progress.
- **STAGE 5 – Preparation:** The community has begun planning and is focused on practical details. Leadership is active and energetic. Decisions are being made and resources are sought and allocated.
- **STAGE 6 – Initiation:** Data are collected that justify a prevention program. Action has begun. Staff are being trained.

- **STAGE 7 – Institutionalization/Stabilization:** Several planned efforts are underway and supported by community decision makers. Staff are trained and experienced.
- **STAGE 8 – Confirmation/Expansion:** Programs have been evaluated and modified. Leaders support expanding funding and scope. Data are regularly collected and used to drive planning.
- **STAGE 9 – Professionalism/High Level of Community Ownership:** Universal, selective, and indicated efforts are in place for a variety of focus populations. Staff is well trained and experienced. Effective evaluation is routine and used to modify activities. Community involvement is high.

STEP 2: CAPACITY

Three ways to increase resources and improve readiness are to:

1. Engage diverse community stakeholders
2. Develop and strengthen a prevention team
3. Raise community awareness of the problem to be addressed

1) Engaging Stakeholders

Stakeholders are the people and organizations in the community who have something to gain or lose by your prevention efforts.

Community prevention efforts should include a broad range of stakeholders including:

- Population groups that the intervention serves
- Mental health
- Primary care
- Suicide prevention
- Behavioral health treatment and recovery
- Tobacco control
- School safety and health
- Highway safety
- Injury prevention
- Violence prevention
- Recovery community
- Reproductive, maternal and child health
- HIV/AIDS prevention
- Substance use treatment
- Education
- Corrections
- Youth
- Law enforcement

2) Developing and Strengthening a Prevention Team

Most communities have some kind of collaborative group, such as a task force, coalition, or interagency group that can serve as your community's prevention team. A collaborative group can be strengthened by:

- Recruiting new members so that a broad spectrum of sectors is represented
- Increasing the prevention knowledge of members through training and technical assistance
- Improving the structure and functioning of the collaborative group

3) Increasing Community Awareness

Raising community awareness of a behavioral health problem can increase readiness of partners and the community to address the problem/take preventive action.

STEP 3: PLANNING

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

Planning encompasses the following tasks:

- Task 1 - Prioritize risk and protective factors associated with the identified problem
- Task 2 - Select prevention interventions that are evidence based, most likely to influence the identified risk factors (conceptual fit), and feasible and relevant to the focus population (practical fit).
- Task 3 - Develop a comprehensive, data-driven prevention plan

Task 1 - Prioritizing risk and protective factors

Two criteria—importance and changeability—can be used to help decide which risk or protective factors to address with prevention interventions.

Importance refers to how much/how strongly a risk or protective factor impacts the targeted behavioral health problem in a community.

Changeability can refer to three issues:

- Whether the community has the capacity to change a particular risk or protective factor
- Whether a suitable evidence-based intervention exists to address a particular problem
- Whether change can be brought about in a reasonable time frame

Task 2 - Selecting effective interventions with good "fit"

There are three criteria for selecting prevention interventions:

- **Effectiveness:** Is the intervention effective?
- **Conceptual fit**: Will the intervention(s) impact the selected risk or protective factor?
- **Practical fit**: Is the intervention appropriate to the community, and/or the specific population or subgroup of focus?

Effectiveness - Refers to whether an intervention was evaluated and found to be effective under a particular set of circumstances. Priority should be given to interventions with strong evidence of effectiveness. For some problems and populations, there may be fewer interventions that are evidence-based.

Conceptual fit - To assess the conceptual fit of an intervention, ask the following questions:

- Does it address the targeted problem?
- Does it address the risk/protective factors and conditions associated with the problem?
- Does it focus on a relevant population and/or context?

Practical fit - To assess the practical fit of an intervention ask the following questions:

- Is it *feasible?* Does the community have the resources needed for the intervention?
- Is there *synergism?* Does the intervention add to or reinforce other prevention interventions?
- Is the community *ready?* Will stakeholders and the community support the intervention?
- Is the intervention *culturally relevant?* Will the cultural groups that are the focus of the intervention be receptive to it? Are they involved in the planning and implementation?

Task 3 - Developing a comprehensive, data-driven prevention plan

A comprehensive plan involves multiple interventions in multiple settings targeting the risk/protective factors identified and adds to what is already happening in the community to address the problem.

A comprehensive prevention plan includes:

- A description of the priority problem and why it was selected
- A list of the prioritized risk factors and how they were prioritized
- A description of community resources, resource gaps, readiness, cultural issues, and how challenges will be addressed
- A description of the interventions chosen to address the selected risk factors
- A logic model with short- and long-term outcomes
- An action plan with timetables, roles, and responsibilities for implementing interventions.

STEP 4: IMPLEMENTATION

Implementation encompasses three main tasks:

Task 1 - Deliver programs and practices.

Task 2 - Balance fidelity with planned adaptations.

Task 3 - Establish implementation supports and monitor implementation.

Task 1 - Deliver programs and practices.

- Increase community awareness of the problem and of the intervention(s) selected to address it.
- Introduce the intervention to stakeholders to obtain their buy-in and expand partnerships.
- Select settings where the intervention will be implemented, and provide resources and support as needed.
- Develop and carry out an action plan detailing what is to occur, who is responsible, and a timeline.

Task 2 - Balance fidelity with planned adaptations.

Fidelity is the degree to which an evidence-based prevention program is implemented as its developer intended.

Adaptation is how an intervention is changed and customized to meet local needs and circumstances.

It is important to balance adaptation with fidelity, because changes to an intervention can compromise its effectiveness.

Guidelines for adaptation:

- Select programs with the best practical fit to local needs and conditions.
- Consult with the program developer.
- Retain core components of the original intervention.
- Add, rather than subtract**.**

Task 3 - Establish implementation supports and monitor implementation.

- Build leadership and administrative support in the settings where the intervention is happening.
- Provide training for the people implementing the intervention if they do not have the necessary skills.
- Monitor the delivery of the program and make mid-course corrections as needed. Your evaluation activities (see Step 5: Evaluation) can help you to monitor implementation of the intervention.

STEP 5: 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 and impact 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, and monitors how the intervention was carried out. Outcome evaluation looks at short-term and long-term results, to see what changes occurred due to the intervention.

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

- Were interventions implemented as planned?
- Who participated and for how long?
- What adaptations were made?
- Were the resources sufficient?
- What obstacles were encountered?

Source: SAMHSA, SAPST, Version 9, February 2018 - Reference #HHSS283201200024I/HHSS28342002T

Outcome evaluation answers the question: "Did our intervention make a difference—did it impact the risk factors and problems 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.

Outcome evaluation data helps to determine the following:

- What changes actually occurred
- How these changes compare to what the intervention was expected to achieve
- How these changes compare with those not exposed to the intervention

Reporting Evaluation Results

Evaluation results are used to improve programs, sustain positive outcomes, and improve a community's overall plan for addressing behavioral health problems and promoting wellness. They can also be used to help obtain funding or to build community awareness and support for prevention.

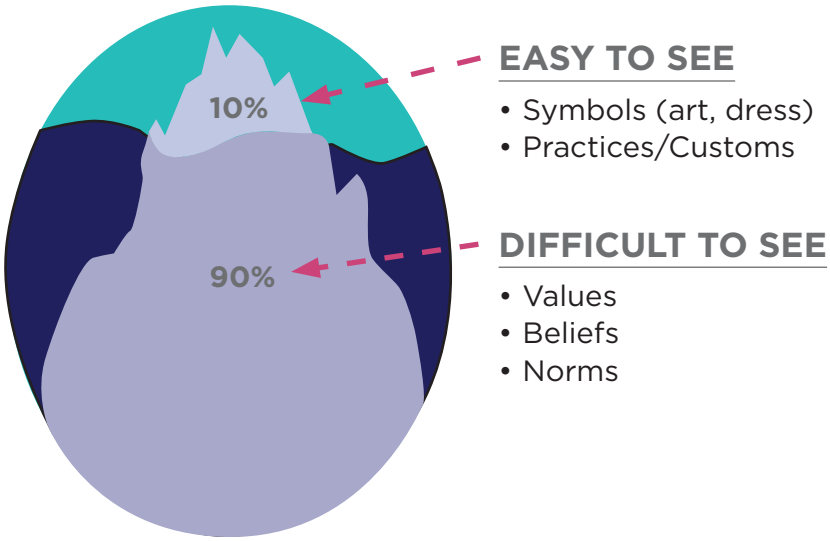
Tips for reporting evaluation results:

- *Brief stakeholders regularly*, throughout the process, not just at the end.
- *Create a dissemination plan,* tailored to the various audiences that need to see the results, including the focus population.
- *Select appropriate reporting formats.* Think carefully about the best venues or vehicles for delivering results.
- *Help stakeholders understand the data.* Remember that each stakeholder has their own interests, and will be most interested in findings that relate to these interests.

Source: SAMHSA, SAPST, Version 9, February 2018 - Reference #HHSS283201200024I/HHSS28342002T

CULTURAL RESPONSIVENESS 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. Culture encompasses a number of elements, including:



- A common heritage and history that is passed from one generation to the next
- Shared values, beliefs, customs, behaviors, traditions, institutions, arts, folklore, and lifestyle
- Similar relationship and socialization patterns
- A common pattern or style of communication or language
- Geographic location of residence (e.g., country; community; urban, suburban, or rural location)
- Patterns of dress and diet

Sources: Griswold, W., Cultures and Societies in a Changing World (3rd ed.), Pine Forge Press, 2008
SAMHSA, Improving Cultural Competence Treatment Improvement Protocol (TIP) Series No. 59, 2014

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 or may not be connected to beliefs and values

While the concept of "culture" applies to groups of people, it is also important to consider how individuals within cultural groups may self-identify. People often have multiple and overlapping identities; in addition to seeing themselves as part of a specific ethnic or religious group, for example, a person's sexual orientation and gender identity are also key aspects of their self-concept and how they interact with the world. In their efforts to develop culturally responsive prevention programs, it is important for Regional Prevention Task Forces to remain aware of these multiple identities, and of the diversity both within and across cultural groups.

KEY CONCEPTS RELATED TO CULTURE IN PREVENTION

To support positive change, prevention practitioners must understand the cultural context of their community of focus, and have the willingness and skills to work within this context. This means drawing on community-based values, traditions, and customs, and working collaboratively with people from the community to plan, implement, and evaluate prevention activities.

SAMHSA uses the term *'cultural competence'* to describe the ability of an individual or organization to interact respectfully and effectively with people of different cultures. Please note that the language in this area is evolving; the term 'cultural competence' may be considered problematic as it may seem to imply the ability to 'master' cultures other than one's own. Alternative terms for this concept include '*cultural responsiveness'* and *'cultural sensitivity'.* The key value underlying all of these terms is a dedication to being respectful of and responsive to the beliefs, practices, and cultural and linguistic needs of diverse people and groups. The related concept of *'cultural humility'* involves an ongoing commitment to self-reflection and self-critique, acknowledging one's own biases and cultural identities, while also striving to understand another person's cultural and intersecting identities.

Fostering cultural responsiveness in organizations and individuals is an ongoing process that involves building:

1. **Cultural knowledge** - Knowledge of cultural characteristics, history, values, beliefs and behaviors of different groups
2. **Cultural awareness** - Openness to the idea of changing cultural attitudes
3. **Cultural sensitivity** - Knowledge of cultural differences without assigning values to the differences
4. **Cultural competence (responsiveness)** - Ability to bring together different behaviors, attitudes, and policies and work effectively in cross-cultural settings to produce better results

Source: CADCA, Cultural Competence Primer: Incorporating Cultural Competence into your Comprehensive Plan, 2018

CULTURAL RESPONSIVENESS IN PRACTICE

Culture affects how people interact with each other and their surroundings. Culture also affects how people think, feel, and act with regard to alcohol, tobacco, and other drug use. This means that effective prevention programs will appreciate and respect all cultures and:

- Accept culture as a leading force in shaping behaviors, values, and institutions
- Recognize and accept that cultural differences exist and affect delivery of services
- Accept that diversity within cultures is as important as diversity between cultures
- Respect the unique, culturally defined needs of various populations
- Recognize that concepts such as "family" and "community" are different among cultures and even for groups within cultures
- Understand that people from different racial and ethnic groups and groups within cultures are served best by individuals who are part of or in tune with their culture
- Recognize that valuing and drawing on the strengths of each culture makes everyone stronger

Source: SAMHSA. Focus on Prevention: Strategies and Programs to Prevent Substance Use. 2020

SAMHSA's Center for Substance Abuse Prevention (CSAP) has identified these principles of cultural competence* to guide prevention planning:

- Include the population/community of focus in all aspects of prevention planning
- 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 (responsiveness) among program staff and hire staff that reflect the community they serve

Source: SAMHSA, A Guide to SAMHSA's Strategic Prevention Framework, 2019

**SAMHSA uses the term 'cultural competence'. An alternative term for this concept is 'cultural responsiveness'.*

As Regional Prevention Task Forces plan and conduct local prevention activities and programming, an essential early step is to look at their needs assessment and strategic plan to identify different cultural groups in their service population.

CULTURAL CONSIDERATIONS IN PREVENTION PLANNING (USING THE SPF FRAMEWORK)

Step 1: Assessment

- Identify sub-populations in your community that face behavioral health disparities
- Identify data gaps and work to fill them
- Share and solicit input about assessment findings with community members, including sub-populations facing behavioral health disparities

Step 2: Capacity

- Build the capacity of prevention practitioners to address disparities, and to provide culturally and linguistically appropriate services
- Develop partnerships that will help engage members of sub-populations facing health disparities in prevention planning efforts

Step 3: Planning

- Ensure the community is represented in the planning process, including members of the focus population
- Identify and prioritize risk and protective factors associated with health disparities
- Include reduction in health disparities as a long-term outcome in your logic model
- Select effective prevention programs that have been developed for and evaluated with an audience similar to the focus population

Step 4: Implementation

- Implement prevention programs that focus on populations experiencing behavioral health disparities
- Involve members of the focus population in the design and delivery of programs
- Adapt/tailor evidence-based practices to be more culturally relevant

Step 5: Evaluation

- Evaluate whether selected prevention programs are having an impact on reducing behavioral health disparities
- Keep track of all adaptations made to interventions/prevention programs
- Conduct follow-up interviews with participants to better understand evaluation findings

Source: SAMHSA, A Guide to SAMHSA's Strategic Prevention Framework, 2019

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 Misuse Prevention.

STATEWIDE AGENCIES AND ORGANIZATIONS:

BHDDH

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH) is the single state authority for substance misuse 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 misuse 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 use disorders, and strengthening and expanding the prevention workforce in Rhode Island.

The Rhode Island Prevention Resource Center (RIPRC)

The RIPRC provides training, technical assistance, and capacity-building resources to Rhode Island substance misuse 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 Misuse Prevention certification system; and foster collaboration between prevention providers and across related state and local initiatives to prevent substance misuse and other risk-taking behaviors in Rhode Island. The RIPRC is a contract with JSI Research & Training Institute, Inc. (JSI).

The RIPRC defines technical assistance (TA) as the process of providing focused support to RI prevention organizations, providers, and partners with identified programmatic needs or problems. TA is an effective method for engaging and building the capacity of prevention providers and organizations.

The Rhode Island State Epidemiology Outcomes Workgroup (SEOW)
The SEOW is administered by BHDDH, and it serves as a clearinghouse for substance use and mental health related data indicators, products, and collaborations. Its mission is to institutionalize data-driven planning and decision making for the purposes of state and community level substance use, misuse, risk and protective factors, consequences, and mental health across the State of Rhode Island. Products of the SEOW include epidemiological profiles, data briefs, publications, and reports for strategic planning, promotion, prevention, treatment, recovery, and policy implications.

Rhode Island Student Assistance Services (RISAS)
RISAS provides evidence-based programs in schools and communities to prevent substance use, and promote mental health to Rhode Island schools and communities since 1987. RISAS is implementing Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students), which is s recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an effective evidence-based program to prevent and reduce substance use among youth ages 12 to 18. Project SUCCESS is implemented in 78 Rhode Island middle and high schools representing 33 school districts. 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)
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 misuse prevention and treatment services which include but are not limited to treatment and recovery-focused training opportunities.

The Rhode Island Certification Board (RICB)
The 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 RIPRC developed the Rhode Island Prevention Specialist Certification Exam Study Guide to aid and help prevention professionals prepare and pass the exam. 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.

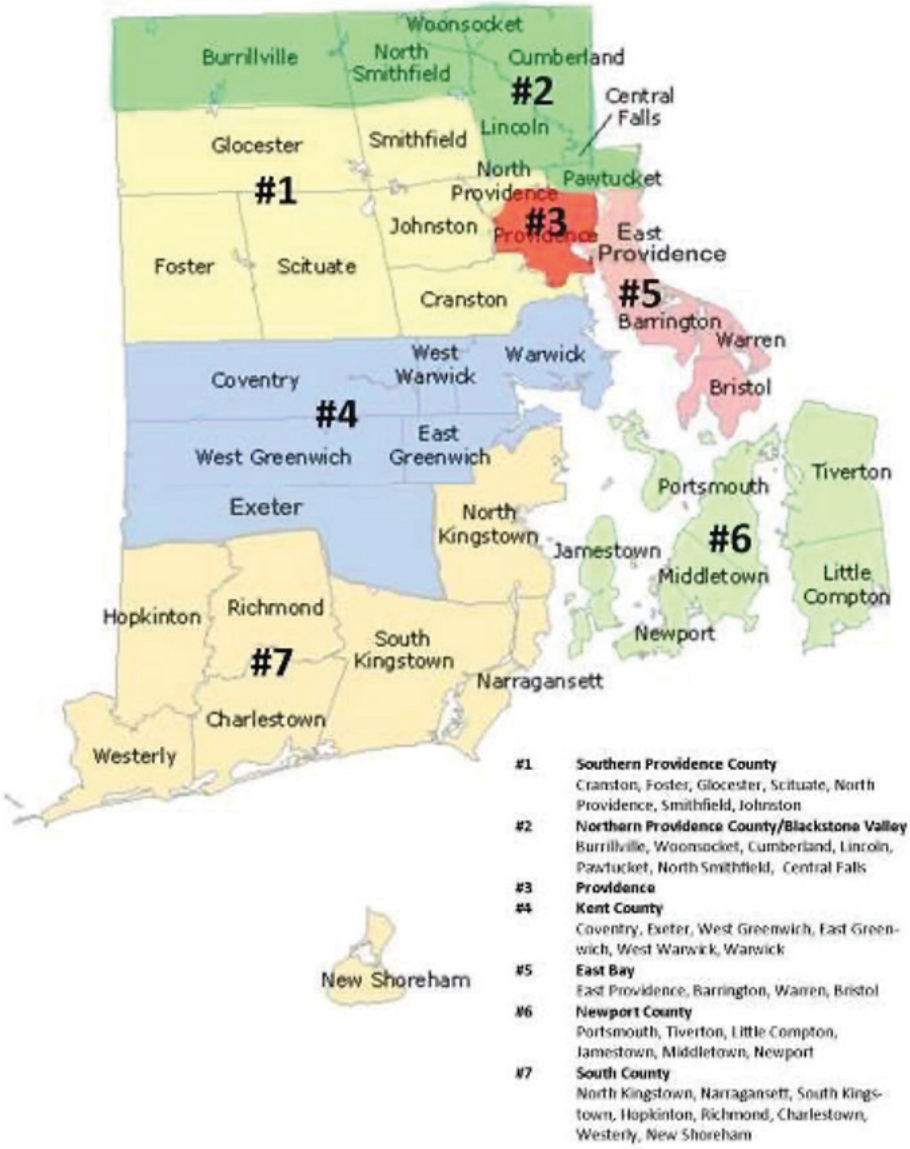
REGIONAL PREVENTION TASK FORCES AND MUNICIPAL PREVENTION TASK FORCES

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 Prevention 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 misuse.

In 2017, BHDDH put in place seven **Regional Prevention 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 task forces 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 Task Forces contributions as part of a larger regional prevention plan.

RHODE ISLAND REGIONAL PREVENTION TASK FORCES

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 (RIDOH)

The RIDOH 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 RIDOH, include tobacco control, substance use prevention, and treatment initiatives and services.

The RI Department of Transportation (RIDOT), Office on Highway Safety

The RIDOT has many initiatives, which include working to prevent drunk and drugged driving and enforce laws against operating under the influence.

The RI Department of Human Services, Division of Elderly Affairs

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 misuse.

The RI Office of the Attorney General

The RI Office of the Attorney General works 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

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 RIDOH and BHDDH serve as community 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)

Health Equity Zones are part of an initiative of the RIDOH. This initiative is an innovative approach to improving well-being. It brings people together to build strong, resilient communities so all Rhode Islanders have the opportunity to be as healthy as possible, no matter who they are or where they live. HEZs work 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.[1]

Tobacco Free RI (TFRI)

TFRI is a statewide network that brings together organizations and individuals working to reduce tobacco and nicotine use in RI. TFRI facilitates communication and shares 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.

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

RHODE ISLAND STRATEGIC PLAN FOR SUBSTANCE MISUSE PREVENTION

State, regional and community-level prevention initiatives should align with the state's Strategic Plan, developed by BHDDH. The Strategic Plan for Substance Misuse Prevention 2020-2024 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

[1] Introducing Rhode Island's Health Equity Zones

- Creating an integrated prevention service delivery system which incorporates a broader behavioral health approach

The Strategic Plan describes *state substance misuse 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 misuse, alcohol dependence or misuse, 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 Misuse Prevention 2020-2024 may be downloaded from the BHDDH website.

FUNDING SOURCES FOR COMMUNITY SUBSTANCE MISUSE PREVENTION

Most funding for community substance misuse 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 Prevention Technology Transfer Centers (PTTC):

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) Since 1993, the SUBG 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

The 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 misuse among adults by addressing the factors in a community that increase the risk of substance misuse, and promoting the factors that minimize the risk of substance misuse. 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 RIDOH may offer mini-grants for which community-based programs may apply.

EXPECTATIONS/SCOPE OF WORK OF REGIONAL PREVENTION TASK FORCES

Research has shown that community coalitions, such as Rhode Island's Regional Prevention Task Forces and Municipal Prevention 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 Prevention 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 misuse among youth and young adults, the mission of the Regional Prevention Task Forces is to enhance the ability of local Municipal Prevention Task Forces to implement evidence-based practices designed to engage communities and attain population level changes in consumption patterns.

The Regional Prevention Task Forces are tasked with providing regionalized coordination, which will increase the capacity of the Municipal Prevention Task Forces, 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 leverage federal and private dollars to address local behavioral health, priorities.

More specifically, the Regional Prevention Task Forces have three priority objectives:

1. To increase the use of evidence-based policies, practices and programs by municipal substance misuse 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. At least one evidence-based practice will be implemented in each member municipality within the region.

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 prevention task forces 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 MOU 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 seven 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)
- Youth and young adults ages 14-25

Regional Prevention Task Force Membership Engagement

CORE RESPONSIBILITIES OF REGIONAL PREVENTION TASK FORCES

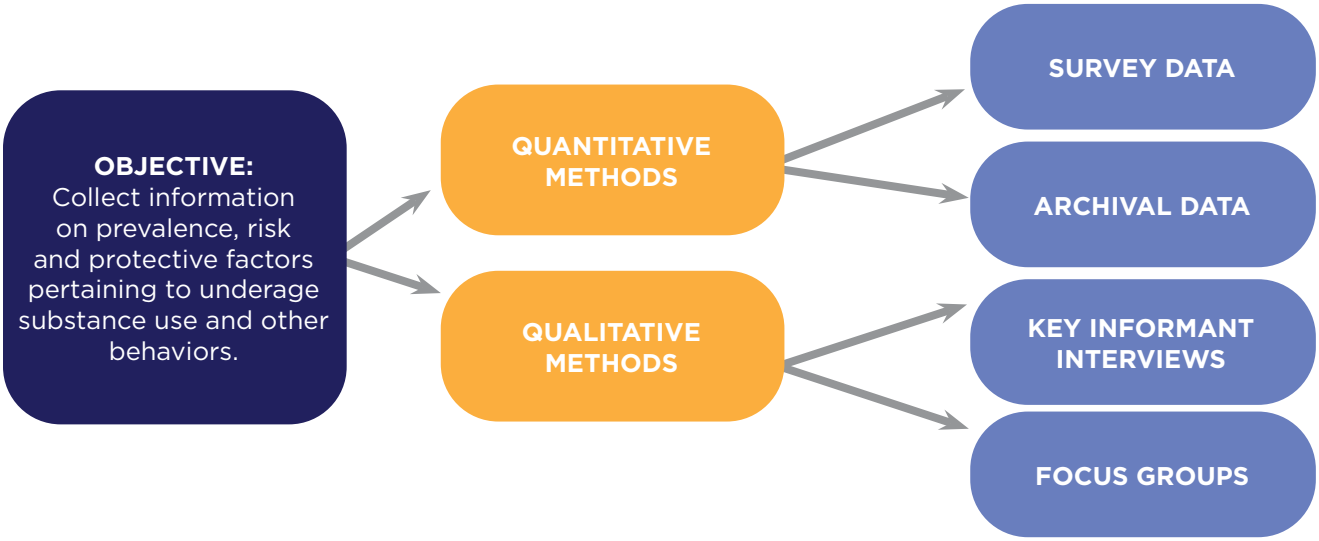
The Regional Prevention Task Forces' overarching goal is to identify and leverage resources to address behavioral health needs within Rhode Island cities and towns by helping communities to provide comprehensive substance use prevention and behavioral health promotion interventions including promoting 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. The needs assessment is required to be completed every three years.

Community Needs Assessment Data Collection



Source: SAMHSA, SAPST, Version 9, February 2018 - Reference #HHSS283201200024I/HHSS283420002T

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 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.

BHDDH provides an anchor tool for the coalitions to document needs assessment data and resources. *To access the RPTF Needs Assessment Review Form and Scoring Anchors, see Appendix 4. To access a list of national, state, and local data sources, see 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 Misuse 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 will review 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 misuse 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;
- *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 misuse prevention services: e.g. systemic planning, community team building, multi-agency coordination/collaboration, community and volunteer training, assessing service and funding.

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)

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

BHDDH provides anchors to document required components of Regional Strategic Plans. *To access the RPTF Strategic Plan Review Form and Scoring Anchors, see Appendix 4.*

MUNICIPAL WORK PLANS

The Regional Prevention Task Force must also assist each 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. Municipal Task Forces must use the required Municipal Task Force Workplan Template to develop these work plans. 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)

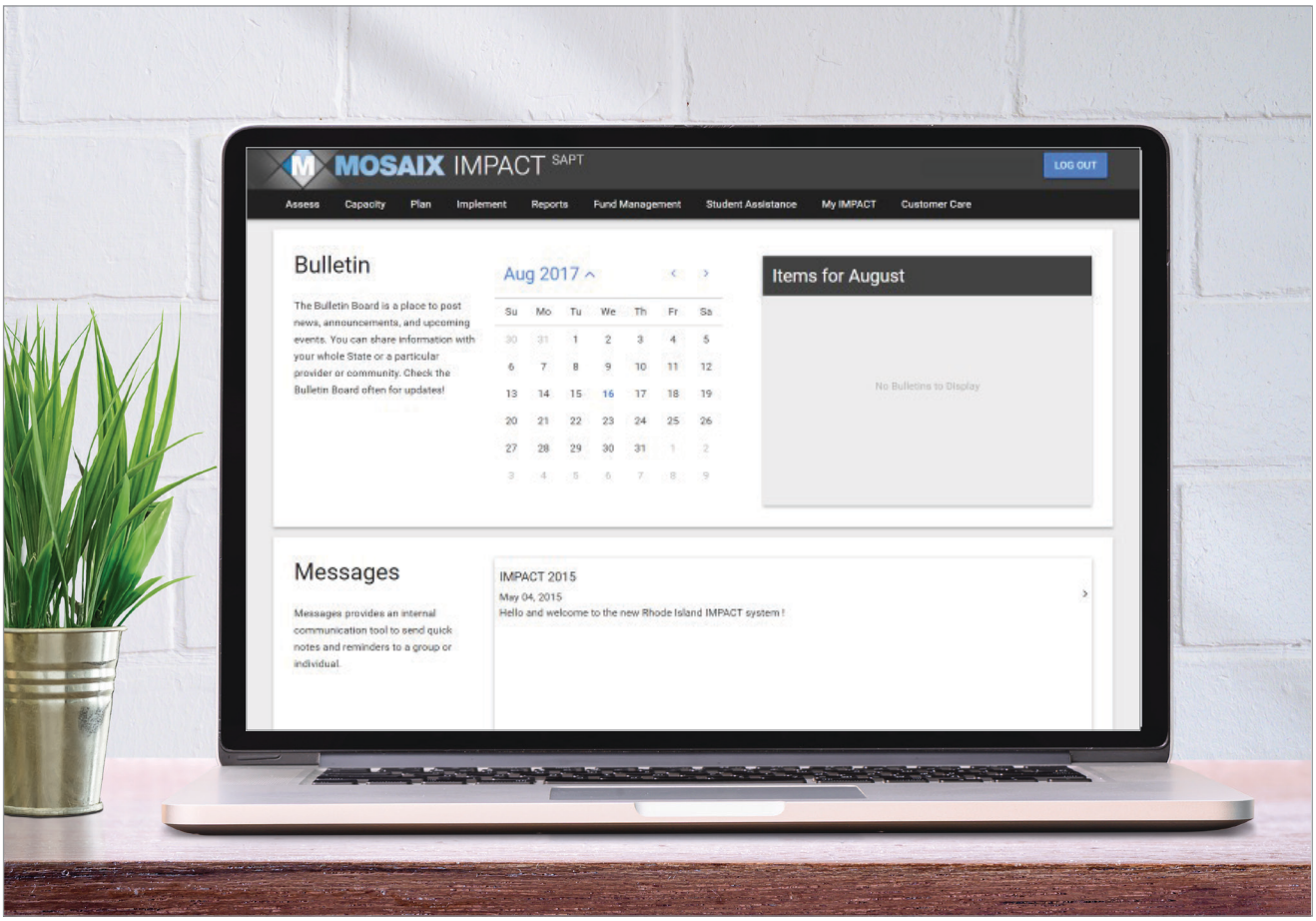
MOSAIX IMPACT SYSTEM FOR REGIONAL AND MUNICIPAL TASK FORCES

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

Sample Mosaix IMPACT Modules

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

Mosaix IMPACT also provides reports in a format that fulfills BHDDH, SUBG Block Grant and other discretionary grants reqirements. The Regional Prevention Task Force contract requires data to be entered into the Mosaix IMPACT by the 15th of the following month.



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 should facilitate and publicize opportunities for their members and others in the community to build their behavioral health knowledge and skills.

Task Force 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.

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

Training Resources for RI Prevention Task Forces

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, PTTC: Center for the Application of Prevention Technologies

New England Institute of Addiction Studies

New England Addiction Technology Transfer Center (ATTC-NE)

SAMHSA, Strategic Prevention Technical Assistance Center (SPTAC)

Prevention Technology Transfer Center Network

TASK FORCE GOVERNANCE AND OPERATIONS

The Regional Prevention 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 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 a 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 sample bylaws from the Providence Mayor's Coalition on Behavioral Health.

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 of a rational problem solving sequence for arriving at decisions, recommendations or actions
- Use humor and positive affect to defuse heated arguments and encourage civil disagreement
- Stress the need for consensus and compromise
- Begin and end the meeting on time.

ROLES AND RESPONSIBILITIES OF REGIONAL AND MUNICIPAL PREVENTION COORDINATORS

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.

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 task force coordinators, as a regional prevention task force 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 designed to measure impact on substance use 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 be a Certified Prevention Specialist (CPS) or be in the process of obtaining this credential/certification.

MUNICIPAL TASK FORCE COORDINATOR

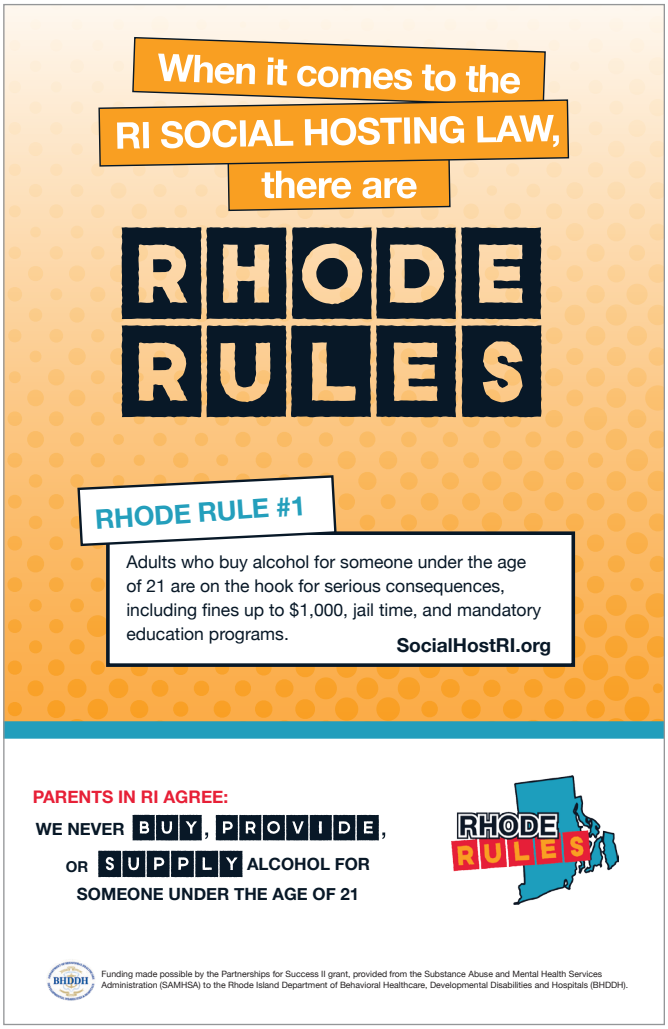
- Identify municipal stakeholders across the seven core sectors.
    - Business
    - Education
    - Medical/health
    - Government
    - Safety
    - Community/family supports
    - Youth and young adults ages 14-25
- Develop a municipal recruitment and retention plan for the seven core sectors
- Recruit and engage multiple municipal representatives of the seven 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 Task Force
- Develop a multi-year municipal prevention plan in collaboration with the Regional Prevention Coordinator
- Develop annual work plans using the required Municipal Task Force Workplan Template detailing the approach described in the municipal prevention plan for the period of the award
- Identify at least one partner among the seven 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

Rhode Island Examples of Prevention Interventions

UNIVERSAL PREVENTION INTERVENTION

These are prevention interventions that focus on the general public or a population that is not identified based on risk factors.

Rhode Rules:
The goal of Rhode Rules is to increase awareness of the Rhode Island Social Host Law through social media and partner engagement awareness strategies across 20 RI towns. Across the United States, alcohol is the most widely used substance among teens and young adults. Consuming alcohol underage poses substantial health and safety risks, including lowered inhibition, impaired judgment, and impacts to a developing brain. States like Rhode Island have passed social host laws (i.e., laws about providing alcohol to underage persons) in an effort to decrease youth access to alcohol, including through one-off purchases or hosting gatherings featuring alcohol. Despite the state's social hosting law, some adults, including parents and siblings, provide alcohol to underage youth. In collaboration with six Rhode Island prevention coalitions, JSI designed a social marketing campaign to 1) increase awareness of Rhode Island's Social Host Law 2) increase awareness of the dangers of underage drinking 3) decrease youth access to alcohol throughout the state. The *Rhode Rules for Rhode Island* social marketing campaign utilizes traditional and digital media channels, including TikTok advertisements and concentrated "Sticker Shock" placements of campaign materials in liquor stores and other locations throughout communities. View the campaign Social Media Toolkit.



SELECTIVE PREVENTION INTERVENTION

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

EastBay Region - InShape PPW Program:
EastBay Region is implementing the InShape PPW program, which was designed to help young adults look and feel more active, fit and healthy using a three-step process of:

1. **Screening** young adults for their current health habits to increase awareness of their substance use and wellness behaviors.
2. **Providing feedback** cuing desired future images and the benefits of engaging in the wellness behaviors and how substance misuse harms them, to increase motivation for change.
3. **Presenting a goal plan** and contract to have young adults set and monitor goals to avoid substance misuse and increase protective wellness behaviors enhancing self-control skills and self-efficacy

INDICATED PREVENTION INTERVENTION

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

RI Student Assistance Program - RI Project Success SBIRT Intervention:
Project SUCCESS is recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an effective evidence-based program to prevent and reduce substance use among youth ages 12 to 18. Project SUCCESS works by embedding a specially trained master's degree level student assistance counselor in each school to provide students with easy access to services. This approach allows for early identification and intervention for alcohol and other drug use-related risk factors, such as drinking at an early age, poor academic performance, tardiness, absenteeism and other behavior problems. One of the interventions delivered through Project Success is provided to the individual student identified as higher risk and in need of additional supports. Within Project Success this service is referred to as Screening, Brief Intervention, Referral to Treatment (SBIRT). SBIRT includes but is not limited to:

- *Confidential Assessment* for alcohol and other drug use and other behavioral health problems that interfere with school performance, attendance, and behavior.
- Individual and/or Group Counseling are time-limited sessions designed to prevent or reduce substance use and foster resilience in youth living with a parent or caretaker with a substance use disorder.
- *Referrals to Substance Abuse and/or Mental Health Treatment Agencies* when appropriate and case management and follow-up services.

APPENDICES

1. Common Acronyms
2. Glossary
3. Important Data Sources
4. Resources, Tools, and Templates
5. BHDDH Budget Tools

Appendix 1: COMMON ACRONYMS

- National
- Rhode Island-specific

NATIONAL

ACEs	Adverse Childhood Experiences
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
ATTC	Addiction Technology Transfer Center
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
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
DEA	U.S. Drug Enforcement Administration
DFC	Drug Free Communities
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
EBP	Evidenced-based practice
FASDs	Fetal Alcohol Spectrum Disorders
FBI	Federal Bureau of Investigations
FDA	Food and Drug Administration

HHS	U.S. Department of Health and Human Services
IC&RC	International Certification and Reciprocity Consortium
IOM	Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine)
IRB	Institutional Review Board
MADD	Mothers Against Drunk Driving
NAMI	National Alliance on Mental Illness
NEIAS	New England Institute of Addiction Studies/AdCare Educational Institute of New England
NASADAD	National Association of State Alcohol and Drug Abuse Directors, Inc.
NIDA	National Institute on Drug Abuse
NOMs	National Outcomes Measures
NPN	National Prevention Network
NIDA	National Institute on Drug Abuse
NOMs	National Outcomes Measures
NPN	National Prevention Network
NSDUH	National Survey on Drug Use and Health
N-SSATS	National Survey of Substance Abuse Treatment Services
OJJDP	Office of Juvenile Justice and Delinquency Prevention
PTTC	Prevention Technology Transfer Center
NDCP	Office of National Drug Control Policy
RADAR	Regional Alcohol and Drug Awareness Resource Network
SAMHSA	Substance Abuse and Mental Health Services Administration
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
SUBG	Substance Use Block Grant
SUD	Substance use disorder
TEDS	Treatment Episode Data Set
TIG	Tribal Incentive Grant[ee]
YRBSS	Youth Risk Behavior Surveillance System

RHODE ISLAND-SPECIFIC

BHDDH	Department of Behavioral Healthcare, Developmental Disabilities & Hospitals
CPRC	Cancer Prevention Research Center
CRST	Community Research and Services Team
DBH	Division of Behavioral Healthcare
DCYF	RI Department of Children, Youth and Families
EOHHS	Executive Office of Health and Human Services
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
RPD	Regional Prevention Director
RSAPC	Regional Substance Abuse Prevention Coalition/Task Force
SEOW	State Epidemiological Outcomes Workgroup
SUMHLC	Substance Use and Mental Health Leadership Council

Appendix 2: GLOSSARY

A

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 the 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 (such as opioids, nicotine or alcohol) characterized by tolerance and by well-defined physiological symptoms upon withdrawal.

Adverse childhood experiences (ACEs): Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur in childhood. ACEs can include violence, abuse, and growing up in a family with mental health or substance use problems. Toxic stress from ACEs can change brain development and affect how the body responds to stress. ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood.

Advocacy: Taking action to support an idea or a cause. Advocates educate community members, the media, and elected officials in order to raise awareness, increase understanding of key issues, and mobilize support with the goal of creating positive change.

Archival data: Data that have already been collected by an agency or organization which are stored in their records or archives.

Assessment: A process of gathering, analyzing and reporting data and information 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 task force.

B

Behavioral health: A state of mental/emotional wellbeing, 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 illness and substance use disorders, and recovery support.

Brainstem: The lower portion of the brain. Major functions located in the brainstem include those necessary for survival, e.g., breathing, heart rate, blood pressure, and arousal.

C

Capacity: The various types and levels of resources that an organization, coalition, or community has at its disposal to meet the implementation demands of specific interventions. Capacity includes both the resources/assets 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 implement prevention activities and strategies.

Cerebellum: A portion of the brain that helps regulate posture, balance, mobility, and coordination.

Cerebral cortex: Region of the brain responsible for higher cognitive functions, including language, reasoning, decision making, and judgment.

CNS depressants: A class of drugs (also called sedatives and tranquilizers) that slow central nervous system (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 readiness: The degree of support for or resistance to identifying substance use and misuse 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 a professional relationship secure and secret from others.

Co-occurring disorder: Having one or more mental health 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 of and responsive to the beliefs, practices, and cultural and linguistic needs of diverse people and groups. Other terms for this concept include *cultural sensitivity* and *cultural responsiveness*. A related concept is *cultural humility* which involves an ongoing commitment to self reflection and self-critique and acknowledging one's own biases and cultural identities, while also striving to understand another person's cultural and intersecting identities.

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, religion or other identity. 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."

D

Depressants: Drugs that relieve anxiety, reduce arousal, 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.

Dopamine: A brain chemical, classified as a neurotransmitter, found in regions of the brain that regulate movement, emotion, motivation, and pleasure.

E

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

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: 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.

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 a small group of like individuals using standardized questions, follow up questions, and exploration of other topics that arise to better understand a prevention-related issue for a particular group of people.

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).

Harm reduction: An approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for

accessing substance use disorder treatment and other health care services.

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.

Hippocampus: An area of the brain crucial for learning and memory.

I

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

Indicated intervention: Indicated prevention interventions focus on higher risk individuals identified as having signs and/or symptoms or behavior foreshadowing a mental health, 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 gasses, such as nitrous oxide.

Intersectionality: A framework to describe how overlapping social identities (such as race, ethnicity, gender, sexual orientation, class, disability, health status) each contribute to and amplify the discrimination and disadvantage experienced by an individual. Intersectionality recognizes that people may experience multiple forms of oppression based on their several identities or groups of which they are part. For example, a young person may face compounded stigma due to their race and gender identity.

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

Limbic system: Area of the brain that is involved with feelings, emotions, and motivations. It is also important for learning and memory.

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 health disorder: Mental health disorders involve changes in thinking, mood, and/or behavior. These disorders can affect how a person relates to others and makes choices, and may cause serious functional impairments that substantially interfere with major life activities.

N

Neuron (nerve cell): A unique type of cell found in the brain and throughout the body that specializes in the transmission and processing of information.

Neurotransmitter: A chemical produced by neurons to carry messages to adjacent neurons.

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

O

Objectives statements: Statements that describe the specific, measurable aims, products and/or deliverables of the project.

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 Behavioral Health Continuum of Care (previously known as the Institute of Medicine (IOM) Continuum of Care):

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/reoccurrence, and/or comorbidity**.** Treatment interventions for substance use disorders include case identification and standard forms of treatment (e.g., detoxification, outpatient treatment, inpatient treatment, medication-assisted treatment).

Maintenance: Maintenance includes interventions (such as aftercare, rehabilitation and recovery support) that focus on adherence to long-term treatment to reduce relapse/ reoccurrence.

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

Prefrontal cortex: Located in the frontal lobe of the brain, this area is important for decision making, planning, and judgment.

Prevention: Interventions that occur prior to the onset of a disorder and which 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: Primarily exploratory research to gain an understanding of underlying reasons, opinions, and motivations. Qualitative data collection methods include focus groups, individual interviews, and participation/observations.

Quantitative data: Research that generates numerical data or data that can be transformed into usable statistics. Quantitative data collection methods include various forms of surveys, longitudinal studies, polls, and systematic observation.

R

Relapse/Reoccurrence: The final stage in the Stages of Change Model. An individual may have a "slip"- revert 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 (you may also see "recurrence" used).

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

Resources: The various types and levels of assets that a community has at its disposal to address identified behavioral health 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 focuses on individuals or subgroups whose risk of developing mental health disorders and/or substance use disorders is significantly higher due to biological, psychological, and/or social risk factors.

Social determinants of health: Social determinants of health (SDOH) are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Examples of SDOH include housing and transportation, education, job opportunities and income, access to nutritious food, air and water quality, racism, discrimination and violence.

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 community.

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.

Stigma: Irrational or negative attitudes, beliefs, and judgments toward people with a particular characteristic, circumstance, or condition (e.g., socioeconomic status, gender, race, sexual orientation, age, medical condition, health status). Stigma often leads to discrimination, which is unjust or prejudicial behavior towards or treatment of different groups of people. People with mental health or substance use disorders often face stigma and discrimination, at the individual level (negative feelings toward self), the interpersonal level (such as in the interactions between providers and clients), the organizational level (as a result of inequitable policies and practices), and at the societal level (for example, broad-based negative perceptions in the community, or unfair application of policies and laws).

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 primarily about maintaining strategies but about achieving and sustaining positive outcomes.

T

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.

Trauma-informed care: SAMHSA defines trauma-informed care as an approach to the delivery of health services, including behavioral health services, that realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, and staff; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively avoid re-traumatization.

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 wellbeing, and not merely the absence of disease or infirmity.

X

Y

Z

Appendix 3: IMPORTANT DATA SOURCES

NATIONAL, STATE, AND LOCAL DATA SOURCES

NATIONAL DATA SOURCES

***Behavioral Risk Factor Surveillance System (BRFSS),* Centers for Disease Control and Prevention**
www.cdc.gov/brfss/
This annual survey, developed in 1984, collects demographic data on adults and information on alcohol use and other health-related risk behaviors. 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**
https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health
NSDUH is an annual survey that looks at the incidence and prevalence of alcohol and drug use, as well as substance use disorders and mental health issues among the civilian, noninstitutionalized population aged 12 or older. Data is also collected about the receipt of substance use and mental health treatment among this population. A national sample is used; regional and state data are also available.

***Youth Risk Behavior Surveillance System (YRBSS),* Centers for Disease Control and Prevention**
https://www.cdc.gov/healthyyouth/data/yrbs/index.htm
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 students in grades 9-12; some state and local data are also available.

***Fatality Analysis Reporting System (FARS),* National Highway Traffic Safety Administration**
https://www.nhtsa.gov/research-data/fatality-analysis-reporting-system-fars
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**
https://www.samhsa.gov/data/data-we-collect/dawn-drug-abuse-warning-network
DAWN, as a national surveillance system, collects data annually on "emergency department visits related to substance use and misuse directly from the electronic health records of consenting hospitals." The information collected includes 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. Five follow-up surveys were conducted in 1996, 2001-2002, 2008, and 2016-2018. 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 conducted every three to four years on various topics related to the educational activities of children and families.Topics include: parent involvement in education, homeschooling, and early childhood education and school readiness. 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 participate in the School Safety and Discipline survey).

***National Crime Victimization Survey (NCVS),* Bureau of Justice Statistics**
https://bjs.ojp.gov/data-collection/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 is also available.

***School Crime Supplement to the National Crime Victimization Survey,* National Center for Education Statistics and Bureau of Justice Statistics.**
https://bjs.ojp.gov/data-collection/school-crime-supplement-scs
This survey collects information from respondents ages 12-18 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, after school activities, availability of drugs and alcohol at school, and other related issues. It is conducted every two years, 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

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)
https://seow.ri.gov/our-work/rhode-island-student-survey
The Rhode Island Student Survey (RISS) is a risk and prevalence survey that is administered biannually in nearly every middle and high school.
The RI Department of Behavioral Health, Developmental Disabilities & Hospitals (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 findings 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 https://seow.ri.gov/.

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.

Appendix 4: RESOURCES, TOOLS, AND TEMPLATES

- Sample Bylaws
  - » The Providence Mayor's Coalition on Behavioral Health Bylaws
- Sample Memorandum of Understanding
- Sample Passive Consent Form
- Sample Needs Assessment and Strategic Planning Tools
  - » RPTF Strategic Plan Review Form and Scoring Anchors
  - » RPTF Needs Assessment Review Form and Scoring Anchors

MAYOR'S COALITION ON BEHAVIORAL HEALTH
BY-LAWS

Notwithstanding any laws to the contrary, the following by-laws are adopted by the Mayor's Coalition on Behavioral Health (MCBH) to facilitate the transaction of business and the exercise of its powers as enumerated in Executive Order Number 2020-17 September 25, 2020. All major action taken by the Coalition will be subject to Mayoral review and approval.

ARTICLE I
Name of Organization

The organization shall be known as the Mayor's Coalition on Behavioral Health

ARTICLE II
Purposes of the Organization

Section 1. MCBH Mission.
The Mission of the Mayor's Coalition on Behavioral Health (MCBH) is to provide leadership, raise awareness and develop policy for the Mayor relating to health, wellness, and safety, including drug, alcohol, and tobacco prevention, across the lifespan.

The mission of the MCBH Coalition states:

- Promoting the health and wellness of individuals and communities in the Providence area.
- Building awareness about behavioral health concerns, focusing on the prevention of substance misuse and mental health challenges.
- Using evidence-based programs, as well as providing tools, resources, and education for community prevention.
- Supporting comprehensive environmental strategies to address systemic challenges.

ARTICLE III
Principal Office and Program Coordinator

The principal office is currently located at 444 Westminster Street, 3rd Floor, Providence, RI. The MCBH will be staffed by a permanent Director and administrative assistant, as funds allow. The Director will assume the MCBH's day-to-day operations and will have discretionary authority to make decisions to ensure its effective operation. Major policy and program decisions will be brought to the Board for an affirmative vote of not less than four members.

ARTICLE IV
Membership

Section 1: Composition of Membership
The MCBH Coalition shall consist of up to 30 members.

Section 2: Composition of the Coalition. As set forth by the Strategic Prevention Framework members will be recruited from the recommended twelve sectors of the community. (Youth, Parent, Business, Media, Schools, Youth Serving Organizations, Law-Enforcement, Civil/Volunteer-organizations, Religious/ Fraternal Organizations, Healthcare Professionals, State/Local/Tribal Government, Substance Used Disorder Organization. Other community members may observe, and record meetings as provided in Article V, Section 4.

Section 3: Term of Office
Members shall serve upon appointment for an indefinite period of time.

Section 4: Resignation of Members
Members may resign at any time by notifying the Director

Section 5: Vacancies
The Director, Chair and Coalition members will work to recruit stakeholders and other representatives of the community in order to have a diverse group of individuals and skills to assist in the conduct of business.

Section 6: Voting Privileges
All members in good standing shall be entitled to one vote on any matter submitted to the membership for approval.

Section 7: Removal from Membership
The MCBH Coalition Director may recommend removal from membership for neglect of duty, incompetence, inability to perform his or her duties, or any good cause by the 2/3rds vote of the coalition members present.

ARTICLE V
Meetings

Section 1: Regular Meetings
The MCBH'S regular meeting of the Coalition will be held on the first Wednesday of each month or such other date as may be established by the Coalition at a location determined by the Director. Notice of regular meetings shall be given 14 days prior to the meeting by electronic mail and the Coalition calendar. Other meetings may be scheduled as needed, as determined by a majority of the Coalition.

Section 2: Annual Meeting
The MCBH Coalition shall hold an annual meeting in December of each year to select officers, review progress on the Strategic Plan, and set priorities for the coming year.

Section 3: Emergency Meetings
Emergency MCBH meetings of the Coalition may be held whenever called by the chair and at least two Coalition members. In no case shall an emergency meeting be called with less than a 48-hour notification, excluding Saturdays, Sundays, and legal holidays.

Section 4: Public Access
All meetings of the MCBH Coalition shall be open at all times for the purpose of permitting members of the public to observe and record them as applicable to Rhode Island General Laws.

Section 5: Quorum
A simple majority of not less than seven (7) members shall constitute a quorum for conducting business and taking official action. All actions must be approved by not less than four members of the Coalition.

Section 6: Agenda
(a) The MCBH Coalition leadership shall prepare an agenda for each regular meeting that will be disseminated to all coalition members, the office of the Secretary of State and posted on the MCBH Coalition calendar no less than one week prior to the scheduled meeting.
(b) Any matter related to the business of the MCBH coalition that is not listed on the agenda may be introduced by any member of the Coalition after those matters on the agenda have been considered.

Section 7: Conflict of Interest
A Coalition member shall disclose any pecuniary interest in any employment, financing agreement, or any other contract made on any action before the MCBH Coalition and shall not vote on the matter. No Coalition member shall participate in discussion on any issue in which they have or has the appearance of having a professional, personal, or financial interest.

Section 8: Basic Components of MCBH Meetings

a) Call to order
b) Approval of the minutes of the previous meeting
c) Announcements
d) Director's report
e) Scheduled Presentations
f) New business/Public Comment
g) Adjournment

Section 9: In the event that a decision needs to be made quickly or in the event of extenuating circumstances, the Director is authorized to convene a Coalition meeting and/or vote electronically.

ARTICLE VI
Subcommittees/ Workgroups

Section 1: Committee Membership, Appointment
The Coalition director, with the approval of the Coalition, may create such subcommittees/workgroups as deemed appropriate. The coalition director shall approve all subcommittee/workgroup members. Potential Coalition subcommittees/workgroups are, but are not limited to

a) Executive
b) Recruitment/Membership
c) Sustainability,
d) Bylaws, and
e) Youth

Section 2: Subcommittee/workgroups Meetings
Proper meeting notification is at least (3) days by postal or electronic service.

ARTICLE VII
Officers

Section 1: Officers
The MCBH officers of the Coalition shall be two Co-Chairpersons. The officers of the Coalition shall constitute the Executive Committee. The Co-Chairs shall share the assigned duties of the Coalition operations.

Section 2: Election
At its annual meeting, the MCBH Coalition shall elect its officers for two (2) year terms.

Section 3: Tenure
The officers shall serve from the date of their election until term is renewed or their successors are elected.

Section 4: Duties of Officers
A Co-Chair shall preside over all meetings of the Coalition and perform all duties commonly incident to the office and perform such duties as the Coalition may designate.

Other Duties
The staff of the Mayor's Coalition on Behavioral Health shall be responsible for recording the minutes of each meeting, preparing meeting notices, maintaining the correspondence/papers of the Coalition, and have care and custody of any financial reports, if applicable.

ARTICLE VIII
Amendments

These by-laws may be altered, amended, repealed or added to by an affirmative vote of not less than a simple majority of the members present.

Proposed amendments shall be made available no later than the previous regular meeting.

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 Form

SAMPLE SCHOOL PARENT LETTER
(Put on School Letterhead) Fall, 2023

Dear Parent,

{*Name of School*}, along with 78 other Rhode Island secondary schools, is implementing a Student Assistance Program based on a national model called Project SUCCESS. The program is provided by Rhode Island Student Assistance Services (RISAS) and is funded by the Rhode Island Department of Behavioral Health and the school department.

The goals of Project SUCCESS are to prevent and reduce substance use and to improve school performance. The program provides school-wide awareness, classroom presentations and individual and small group sessions to teach about the effects of substance use and skills to resist pressures to use substances.

{Name of Counselor}, our Student Assistance Counselor will implement Project SUCCESS prevention and education activities at {name of school}. (*pronoun)* works full-time (*or part-time*) and is available to meet with parents. *{SAC name)* has a Master's Degree in (*field*), and specialized training in substance use prevention and mental health promotion. The Student Assistance Counselor is an employee of RISAS and is supervised by RISAS and the School.

{SAC name} is available to see students who are experiencing personal, school or family problems that could put them at risk of substance use or other unhealthy behaviors. If you are worried about your child, reach out to the Student Assistance Counselor or encourage your child to connect directly with *(pronoun)* at school. You can call *(pronoun)* at (*SAC's Phone # and extension*). All calls will be confidential.

This program has helped many students make responsible choices and has helped others get outside help for related problems. To evaluate the effectiveness and improve the program, the state requires us to collect data from students who participate during the school year. No names are on any collected data.

If, for any reason, you do not want your child to be seen by the Student Assistance Counselor, please contact the Student Assistance Counselor or me directly. We are very pleased to offer this valuable program to the students in our school.

Also, please feel free to contact me if you have any questions about the program.

_____
Principal

RI Department of Behavioral Healthcare, Developmental Disabilities, & Hospitals

RI Regional Prevention Task Force Coalitions' Strategic Plan Scoring Rubric

(revised 12/5/2023)

COMMUNITY NAME:

RI REGIONAL PREVENTION TASK FORCE: LOCAL STRATEGIC PLAN

GUIDANCE DOCUMENT REVIEW FORM/ reviewer initials

SECTION 1 – SPF STEP 3: PLANNING- STRATEGIC PLAN

Table 1 - SCORING ANCHORS
SPF STEP 3 - PLANNING

COMMUNITY NAME:

RI REGIONAL PREVENTION TASK FORCE: LOCAL STRATEGIC PLAN

GUIDANCE DOCUMENT REVIEW FORM/ reviewer initials

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 in deciding which substances or risk factors were given priority and targeted in the strategic plan. From final submission, appended minutes from Regional meeting	Discussion of decision-making process/structure in deciding which substances or risk factors were given priority and targeted in the strategic plan. and, for final submission, appended minutes from Regional meeting	Discussion of decision making in deciding which substances or risk factors were given priority and targeted in the strategic plan. process/structure and, for final submission, appended minutes from Regional meeting
No discussion of who made the final decision. From final submission, appended minutes from Regional meeting	Discussion of who made the final decision. From final submission, appended minutes from Regional meeting	NA
No discussion of the specific EBP selected. From final submission, appended minutes from Regional meeting	Discussion of the specific EBP selected. From final submission, appended minutes from Regional meeting	NA
No justification for the specific EBP selected. From final submission, appended minutes from Regional meeting	Justification provided for the specific EBP selected. From final submission, appended minutes from Regional meeting	Justification provided for the specific EBP selected and linked back to all assessments conducted in Step. From final submission, appended minutes from Regional meeting
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

COMMUNITY NAME:

RI REGIONAL PREVENTION TASK FORCE: LOCAL STRATEGIC PLAN

GUIDANCE DOCUMENT REVIEW FORM/ reviewer initials

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** 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, using the BHDDH template, covering a priority problem and related risk/protective factors is provided	A community logic model, using the BHDDH template, 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.

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

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 2 - 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 are provided.	A task and timeline are provided in the template format.	The task and timeline are 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(is) 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 3 - 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, 2020, 2022, and 2024 is mentioned	Administration of the RI Student Survey in 2018,2020, 2022, 2024 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" which provided several 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.

RI Department of Behavioral Healthcare, Developmental Disabilities, & Hospitals

RI Regional Prevention Task Force Coalitions' Needs Assessment Scoring Rubric

(revised 12/5/2023)

COMMUNITY NAME:

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

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 . Compared sub-population level data to the general population data.

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 of the consequence or the problem 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 the key informant interviews with 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) such as driving after substance use, 30-day prevalence data, school related data, or treatment admissions.	Described at least one factor, such as driving after substance use, 30-day prevalence data, school related data, or treatment admissions, considered in an effort to identity a priority consumption pattern even if one did not emerge.	Described two or more factors, such as driving after substance use, 30-day prevalence data, school related data, or treatment admissions. 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	Discussion and analysis of impacts on more than one sub-population **AND/OR** engagement of community leaders in

	identified in assessment	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:

Table 1E- SCORING ANCHORS
SPF STEP 1 - SUSTAINABILITY

INADEQUATE: fails to	**MEETS**	**EXCEEDS**

address the minimum required elements	**REQUIREMENTS**: addresses the minimum required elements	**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

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" (October 2021) 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


DEPARTMENT OF BEHAVIORAL HEALTHCARE
DEVELOPMENTAL DISABILITIES & HOSPITALS
RHODE
STATE OF
ISLAND
BHDDH
HOPE


RIPRC