State of Rhode Island

Final

Strategic Plan for

Substance Abuse Prevention

2016-2019

SECTION 1 - INTRODUCTION

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is the single state authority for substance abuse prevention and treatment. BHDDH and key stakeholders, who have a vested interest in prevention, have collaborated to develop the following strategic prevention plan. The purpose of this plan is to outline BHDDH's primary goals and strategies to strengthen the infrastructure and to provide support at the State and community-level to prevent and reduce the use of alcohol, tobacco and other drugs among youth and young adults. BHDDH utilizes a life span framework-across the Institute of Medicine (IOM) care continuum focusing on priority populations and activities, including but not limited to substance abuse prevention, mental health promotion, violence prevention and tobacco control to promote health and mental wellness in Rhode Island (RI). The life span (course, or stages) framework helps to explain health and disease patterns, particularly health disparities, across populations and over time.

Equally important, BHDDH implements a population health model by integrating prevention and mental health promotion across behavioral health systems. This model aims to improve the health of the entire population and to reduce health inequities among population groups. By focusing on the integration of prevention and mental health promotion across the State's behavioral health system, BHDDH is developing a stronger infrastructure to leverage efficiencies and opportunities for increased coordination, collaboration, and sustainability.

The plan reflects on-going efforts to use data and key stakeholder and community participation to set goals and objectives; prioritize evidence-based programs, practices, and policies; coordinate activities; determine key data indicators and evaluation plans to measure outcomes; identify target populations to improve health equity and reduce disparities related to substance use and mental illness; and plan for the sustainability of infrastructures and activities. The aim of this plan is to provide a roadmap to:

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

BHDDH utilizes the Strategic Prevention Framework (SPF) developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). The framework uses a five-step process to assess state and community prevention needs across the life span. The SPF is built on principles of outcomes based prevention, a community-based risk and protective factors approach to prevention, and a series of guiding principles appropriate for use here in RI at the state and community levels. The SPF stresses the use of findings from public health research along with evidence-based prevention programs to build capacity across various geographies and populations to promote resilience and decrease risk factors in individuals, families, and communities. Cultural competency and sustainability are infused into each of the SPF steps outlined below.

The steps of the Strategic Prevention Framework require-RI and its communities to systematically:

- Assess prevention needs based on epidemiological data

- Build prevention capacity
- Develop a strategic plan
- Implement effective community prevention programs, policies and practices, and
- Monitor, evaluate and document outcomes

Developing an integrated behavioral health infrastructure is an on-going process. It is important to note that 2016 begins a transitional period as the State rolls out a new prevention service delivery model. It is of paramount importance that the State, its providers, and stakeholders identify the necessary changes to work towards creating greater behavioral health equity in the State. The State aspires to provide equity by offering the highest level of behavioral health to all people and supporting concerted efforts for those who have experienced social and/or economic disadvantages. The details of the State's amended strategic plan are presented below.

SECTION 2- RHODE ISLAND PREVENTION INFRASTRUCTURE OVERVIEW

There are several important components of the State's prevention infrastructure that play an important and distinct role in the substance abuse prevention system in Rhode Island. Each group highlighted below, supports the mission of BHDDH and has helped to provide strategic direction for this plan.

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

Prevention Advisory Committee- The PAC is a committee of the Governor's Council on Behavioral Health. The PAC provides recommendations to the Governor's Council which is integrated into the annual report to the Governor and to the state's federal block grant application. The group's goals are to broaden the focus of substance abuse prevention efforts, integrate partnerships in prevention; reach populations that have been hard to reach; integrate systems for better evaluation and data collection; define prevention within the Affordable Care Act (ACA); work to eliminate health disparities and stigma around mental health and substance abuse disorders; and coordinate efforts across state departments and community providers. The PAC is committed to strengthening and expanding the prevention workforce in Rhode Island.

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

Rhode Island State Epidemiology Outcomes Workgroup (SEOW) - The primary mission of the SEOW is to guide in institutionalized data-driven planning and decision making relevant to substance

use/abuse and mental illness across Rhode Island. As such, the SEOW operates within the outcomes-based prevention framework, aiming to integrate prevalence and incidence data with risk and protective factors data into its decision-making process and policy-making at the state and community level.

Rhode Island Student Assistance Services (RISAS) - RISAS has been providing school and community-based substance abuse prevention and early intervention services to Rhode Island schools and communities since 1987. RISAS is implementing Project SUCCESS, an evidence-based SAMHSA program, in over 40 Rhode Island middle and high schools.

The Rhode Island Certification Board - The RI Certification Board defines a baseline standard for all credentials offered. Providers are given recognition for meeting specific predetermined criteria in behavioral health services. 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.)

Rhode Island Substance Abuse Prevention Act (RISAPA) - In 1987, the Rhode Island General Assembly passed the Rhode Island Substance Abuse Prevention Act (RISAPA) to promote comprehensive prevention programming at the community level. Thirty-four municipal task forces, covering almost all of the State's 39 cities and towns, engage in local needs assessments; and planning, implementation, and evaluation of strategies, policies, and programs to produce long-term reductions in substance use and abuse.

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 while promoting a collaborative, coordinated system of comprehensive community based mental health, substance abuse prevention and treatment services which include but are not limited to treatment and recovery focused training opportunities.

SECTION 3 - STATE SUBSTANCE ABUSE PREVENTION PRIORITIES BASED UPON THE 2015 RHODE ISLAND STATE EPIDEMIOLOGICAL PROFILE

The most recent Rhode Island State Epidemiological Profile (State EPI Profile) was completed in 2015. The purpose of the profile is to inform and assist in data-driven state and community-level planning and decision making processes relevant to substance use and mental health issues across the State of Rhode Island. The profile provides a comprehensive set of key indicators – micro level to macro level – describing the magnitude and distribution of:

- Substance use consumption patterns (alcohol, tobacco, and other drugs), as well as their negative consequences across the lifespan
- Potential risk and protective factors associated with substance use and mental illness
- Behavioral health outcomes across the State of Rhode Island

The profile is guided by an outcomes based prevention framework, and as such, it identifies the specific areas of need by analyzing consequences of substance abuse and consumption patterns as well as related risk and protective factors from all ecological levels that helped to drive the strategic planning process.

The Substance Use and Mental Health in Rhode Island (2015): A State Epidemiologic Profile ("2015 State Epi Profile") identifies key behavioral health findings based on national and regional data sets. This strategic plan incorporates and adopts a sub-set of these priorities which are then integrated, as appropriate, within the formulation of goals, objectives and activities described in this plan. Several factors lead to the selection of actionable priorities.

- Not all priorities or recommendations from the 2015 State Epi Profile are changeable within the time frame addressed with this current prevention strategic plan

- Some priorities are not changeable with primary prevention strategies

- Evidence based or evidence informed interventions fundable with the primary prevention set aside of the Substance Abuse Block Grant may not exist to address the priority

Please consult the full 2015 State Epidemiological Profile for additional analysis and information that provides the justification for the priorities noted in this plan. Time trend charts have been provided within body of this plan. The link to the Profile is available at www.riprc.org.

A. CONSEQUENCES OF SUBSTANCE USE - Priority Consequences for 2016-2019 Strategic Plan for Substance Abuse Prevention

The following priority consequences will be targets for primary prevention strategies based on their severity as compared to US rates or troubling trends. They include:

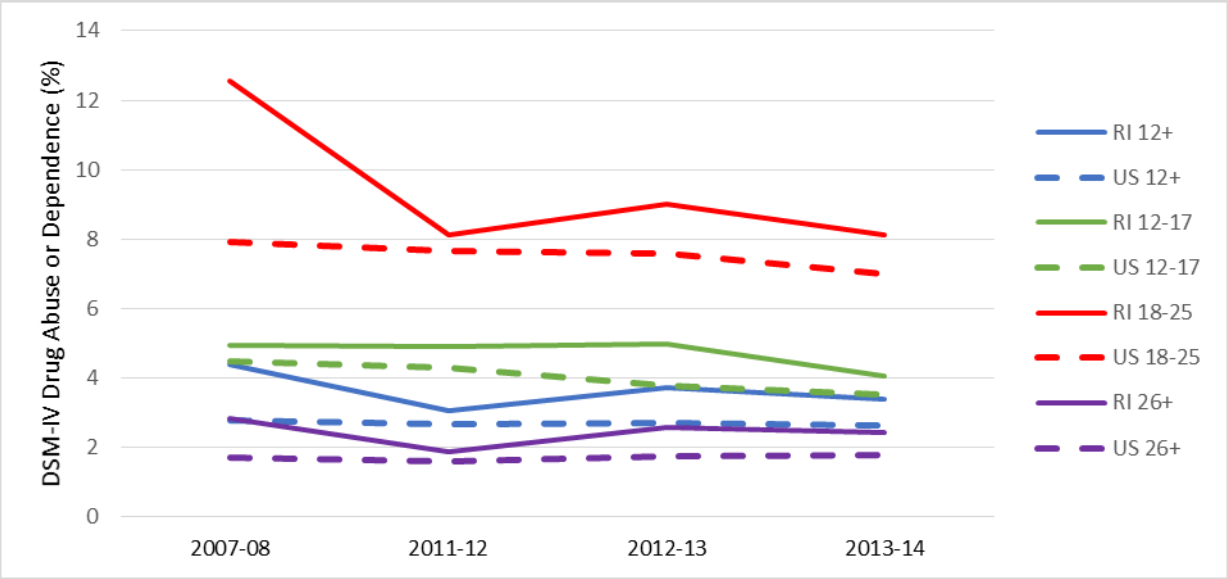
A. DSM-IV diagnosis of illicit drug dependence or abuse

B. DSM-IV diagnoses of alcohol dependence or abuse

C. Drug overdose, especially those attributed to opioids and prescription drugs

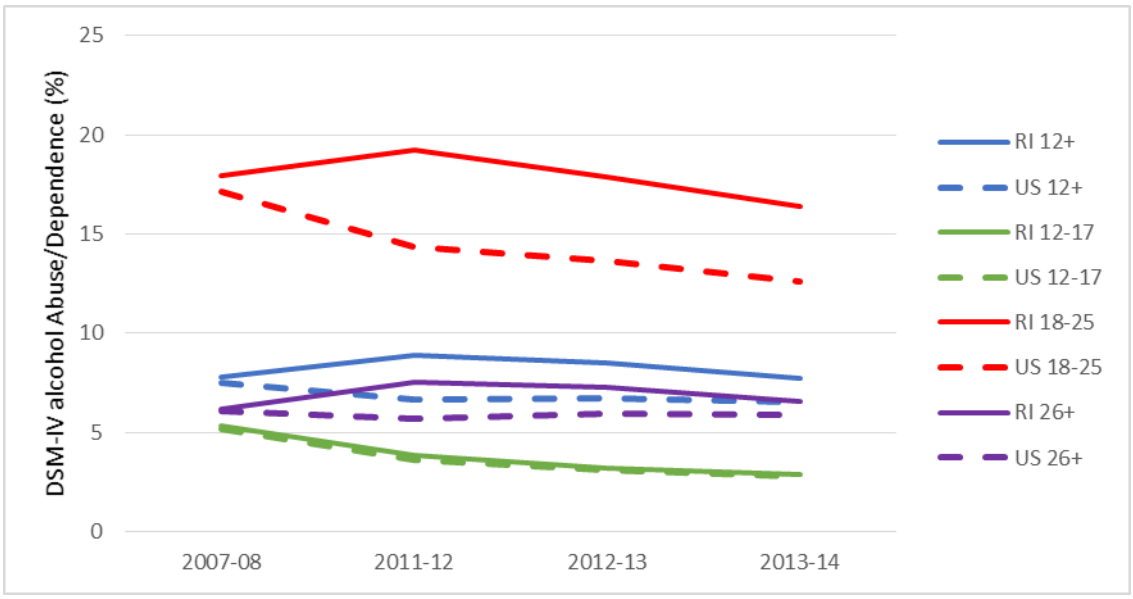
D. Suicide attempts among adolescents

RI vs. US DSM-IV Drug Abuse or Dependence by Age Group, 2007-2014
2015 State Epi Profile - Figure 2.1.4.



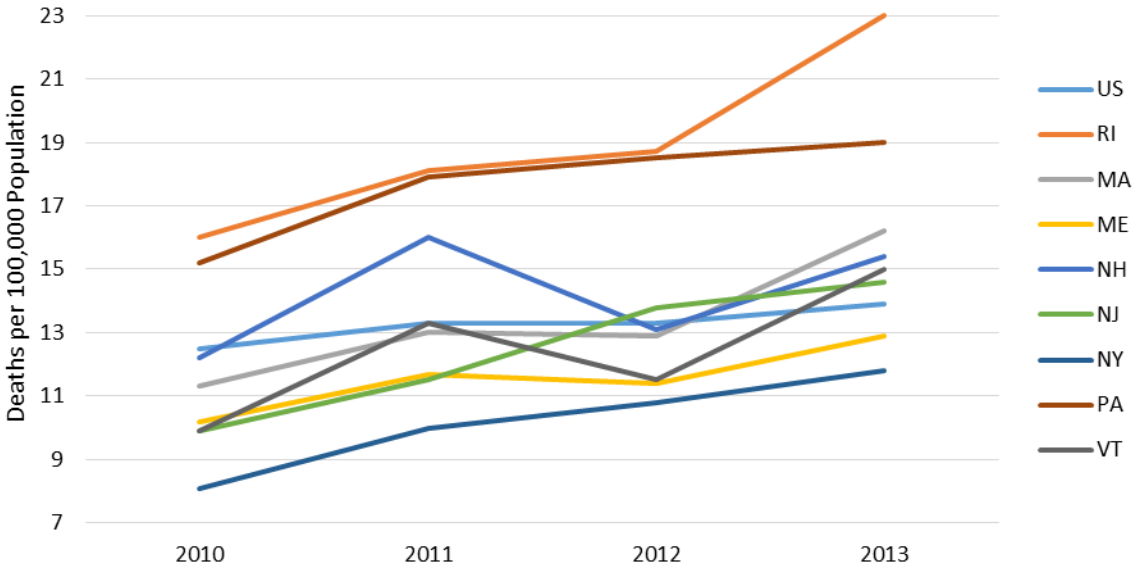
Source: National Survey on Drug Use and Health (NSDUH).

RI vs US DSM-IV Alcohol Abuse or Dependence by Age Group, 2007-2013
2015 State Epi Profile - Figure 2.2.1.



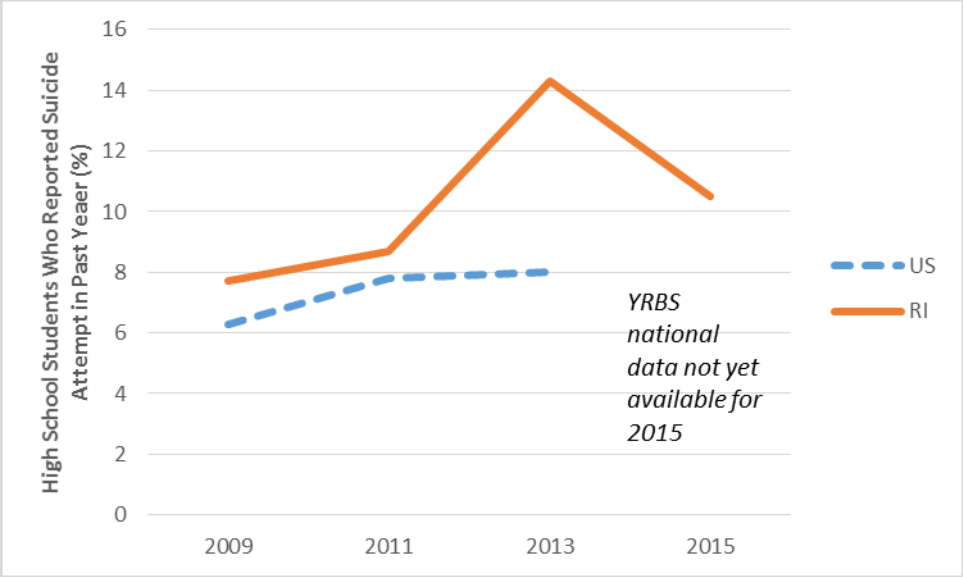
Source: National Survey on Drug Use and Health (NSDUH).

Figure 2.4.2. Drug-Related Overdose Deaths, 2010-2013



Source: Death certificate data: National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Mortality Detail files, 2010-2013. **2015 RI State Epi Profile.**

RI vs. US High School Students Grades 9-12 Who Attempted Suicide in the Past Year, 2009-2015



Source: Youth Risk Behavior Survey, Centers for Disease Control

While DSM-IV diagnoses of dependence or abuse are potentially changeable with primary prevention strategies, it will take considerably longer than the time frame covered in this strategic plan. Similarly, while primary prevention efforts are important to stem the opioid overdose crisis in Rhode Island, we are restricted to using primary prevention funds for the purposes of educating and informing the community and partners/stakeholders about the risk of overdose and effective strategies for curbing the overdose epidemic.

Lastly, the percentage of youth who reported attempting suicide as compared to US percentages overall is slightly elevated[1]. This selection of priority consequence is based on the ability to reduce suicide attempts by addressing shared risk and protective factors between substance abuse and suicide.

[1] Please note that the 2013 percentages reported in the chart above are believed to be an anomaly based on the RI Department of Health's review of other data for the same time frame

B. CONSUMPTION PATTERNS - Priority Consumption Patterns for 2016-2019 Strategic Plan for Substance Abuse Prevention

The following priority consumption patterns will be targets for primary prevention strategies based on their severity as compared to US rates, troubling trends or to maintain primary prevention efforts that have resulted in reductions in use or favorable trends in the right direction. BHDDH would seek a reduction on the magnitude of 3-4 % with consumption rates that exceed national averages so that RI rates are at or below national averages among those populations for which there is valid and reliable survey instruments that can be used at the sub-state level. The time frame in which measurable change would be expected is five to seven years, which extends beyond the time period covered by the plan. Where Rhode Island consumption patterns are at or below national averages, BHDDH will continue to implement efforts to maintain below national averages. The priority consumption patterns include:

A. Marijuana use by adolescents ages 12-17

B. Use of illicit drugs other than marijuana 12-25

C. Underage drinking 12-20

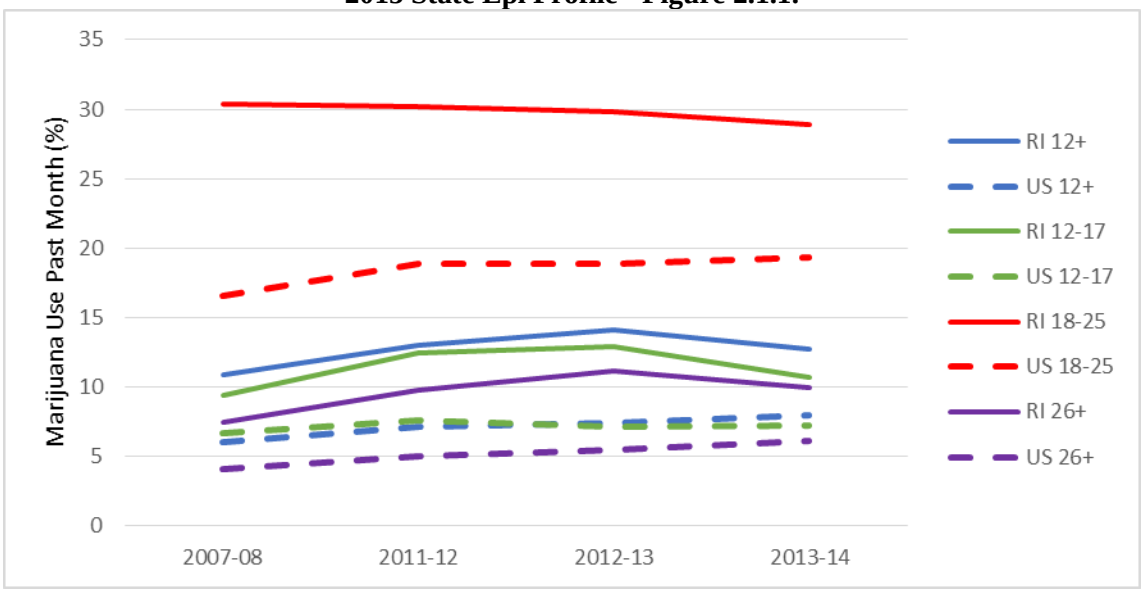
D. Youth use of tobacco or tobacco related products especially use of electronic nicotine delivery systems (ENDS).

Marijuana Use by Adolescents

Regarding findings related to youth marijuana use: relevant tables from the 2015 State Epidemiological Profile include Tables 2.1.1 and 2.2.0 featuring trend data from 2007-2008 to 2013-2014 from the Substance Abuse Mental Health Services Administration's National Survey on Drug Use and Health, and Tables 2.1.9 and 2.2.3 from the Centers for Disease Control's Youth Risk Behavior Survey which includes trend data from 2001-2015.

Major findings from the NSDUH are that RI has exceeded the national average for use across the life span since 2007-2008 by substantial margin of almost double the national rates in some age categories. These rates had significant decreases from 2012-2013 to 2013-2014 but the rates were still considerably higher than the national average.

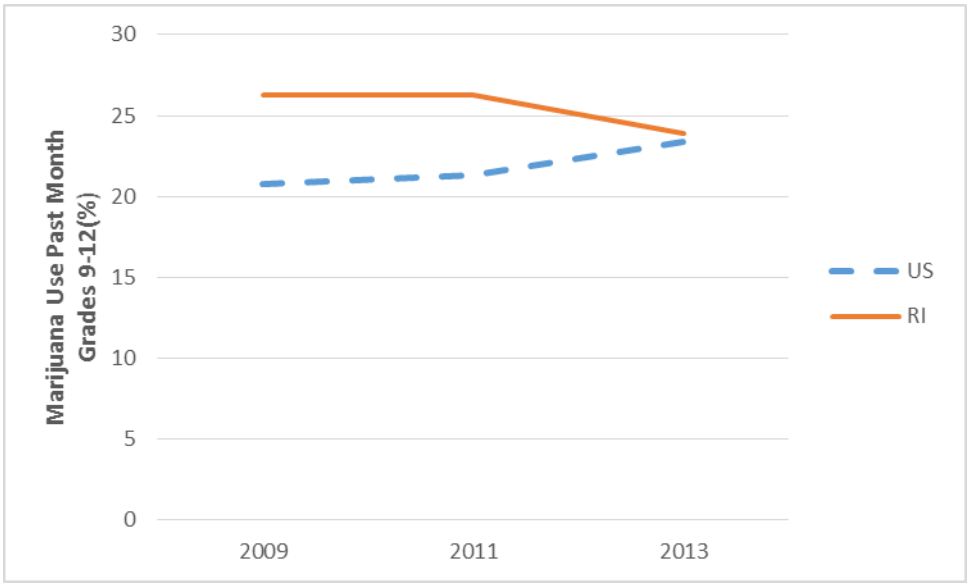
RI vs. US Marijuana Use Past Month by Age Group, 2007-2014
2015 State Epi Profile - Figure 2.1.1.



Source: National Survey on Drug Use and Health (NSDUH)

Primary prevention efforts to reduce marijuana use among adolescents may also produce beneficial effects among young adults over the long term as initiation primarily occurs prior to the age of 18. Various BHDDH managed funding streams have been targeting youth marijuana use since 2010 and as the chart above indicates, *marijuana use among 12-17 has begun to decline after a several years of increases even though it continues to be higher than national averages*.

RI vs. US Youth Marijuana Use Grades 9-12, 2009-2013



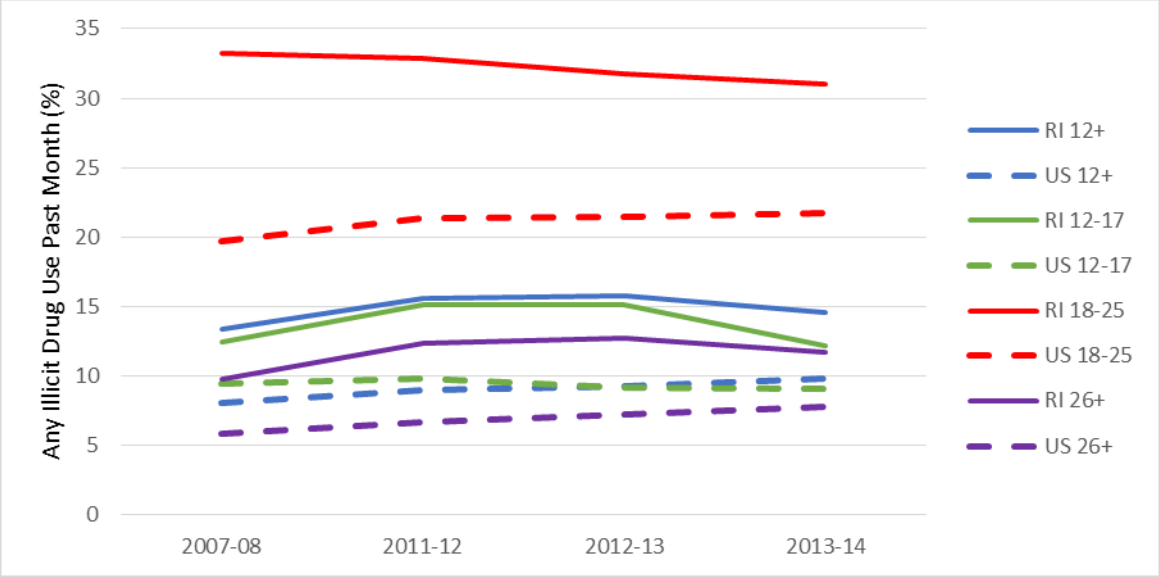
Source: Youth Risk Behavior Survey, Centers for Disease Control

The Youth Risk Behavior Survey results indicate that among a statewide sample of RI high school students, underage marijuana use – even though there was a decreasing trend from 2001 to 2009 – remained the only underage substance use consumption indicator with prevalence greater in Rhode Island than in the rest of the country. Rhode Island's percentage has been declining since 2009 while the US percentage has been increasing.

Illicit Drug Use

With respect to data from the National Survey on Drug Use and Health (NSDUH) the doubling of the illicit drug use among persons older than 12 years of age in Rhode Island, from 3.0% in 2000 to 5.9% in 2007-2008, resulting in an 64% greater illicit drug use in Rhode Island in 2007-2008 than in the rest of the nation.

RI vs. US Any Illicit Drug Use Past Month by Age Group, 2007-2014
2015 State Epi Profile - Figure 2.1.0.

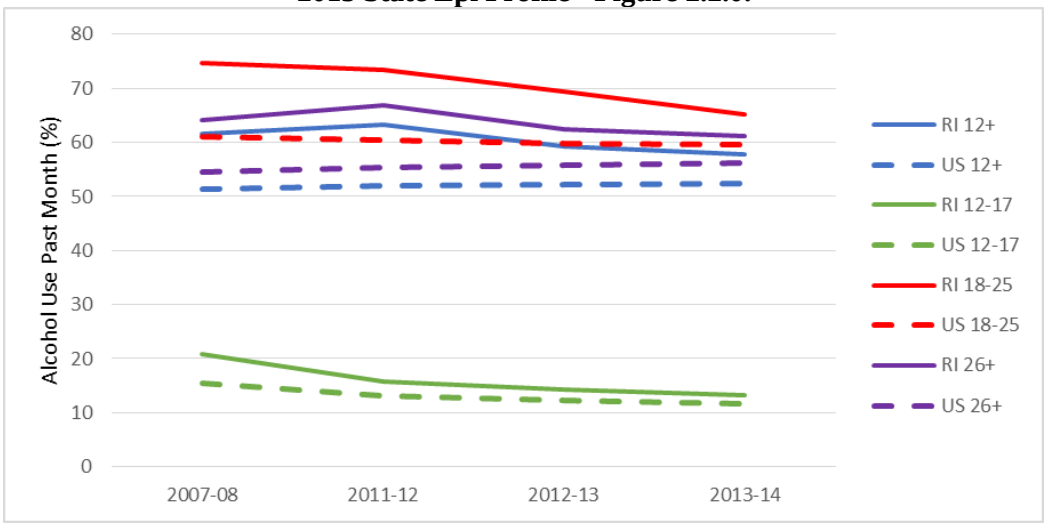


Source: National Survey on Drug Use and Health (NSDUH)

Underage Drinking and Past 30 Day Use Among Young Adults 18-25

Rates of past month use of alcohol as reported in the NSDUH indicate that there is a downward trend between 2007-2008 and 2013-2014 across all age ranges although these rates are slightly higher than the national average across all age ranges.

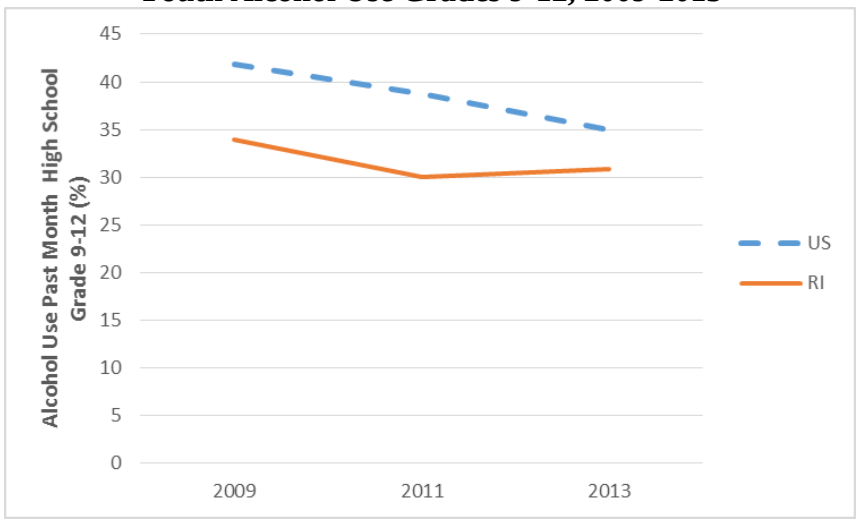
Alcohol Use Past Month by Age Group, 2007-2014
2015 State Epi Profile - Figure 2.2.0.



Source: National Survey on Drug Use and Health (NSDUH)

These results are consistent with those for high school youth reporting past 30 day use of alcohol on the YRBS with rates generally below the national average between 2009 -2013. As for rates of initial use prior to age 13 reported in the YRBS, *the rates of RI high school students reporting past month alcohol use which was once highest within the Northeast region is now below national averages.* Continued efforts to sustain these positive outcomes are necessary. See YRBS time trend chart below.

Youth Alcohol Use Grades 9-12, 2009-2013

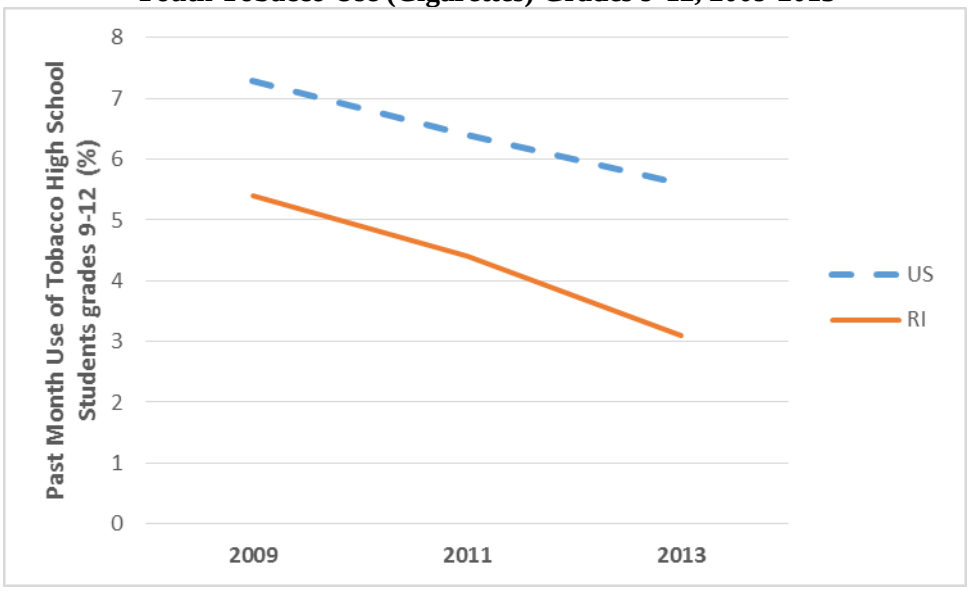


Source: Youth Risk Behavior Survey, Centers for Disease Control

Youth Tobacco Use

Even though the national trends for smoking also declined in this time period, reduction in these consumption trends was greater for Rhode Island. The 2015 Youth Risk Behavior Survey reported *40% of high school youth (grades 9-12) reported using electronic vapor products (electronic nicotine delivery systems). This constitutes an emerging need.*

Youth Tobacco Use (Cigarettes) Grades 9-12, 2009-2013



Source: Youth Risk Behavior Survey, Centers for Disease Control

C. RISK & PROTECTIVE FACTORS

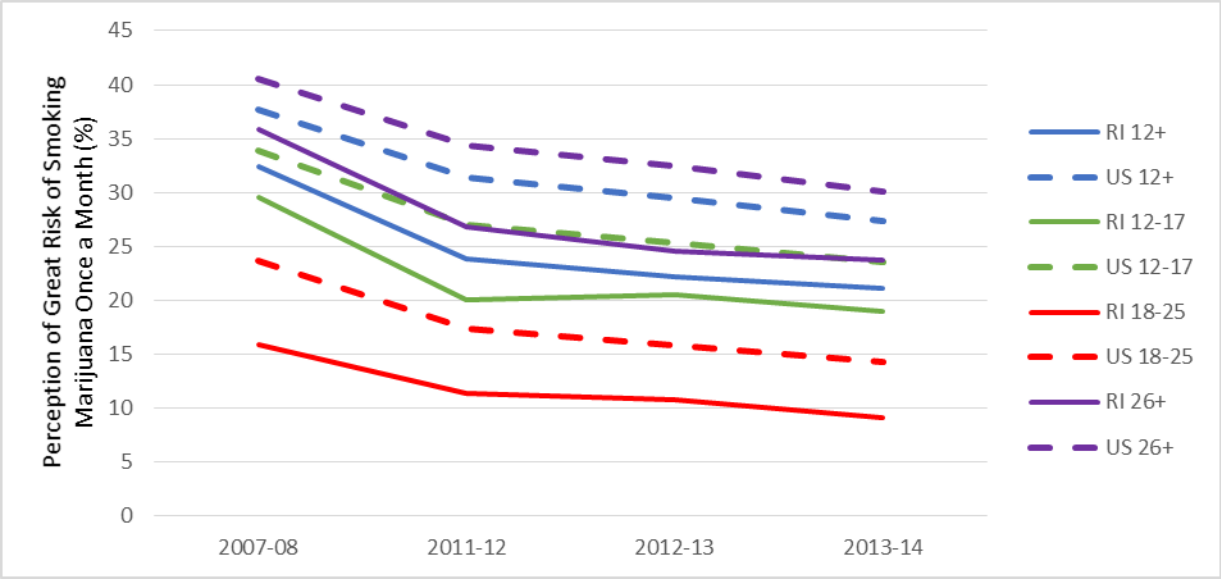
State or community level indicators related to behavioral health risk or protective factors are not as readily available as other indicators of consumption or consequences. The priority risk or protective factors are those that appear in research studies related to prevention of substance abuse. Currently, RI has limited access to risk or protective factor data, but efforts are being undertaken to address this gap through widespread use and implementation of the Rhode Island Student Survey, a risk and prevalence survey currently being administered bi-annually in all but four school districts.

BHDDH provides funds through the Substance Abuse Prevention and Treatment Block Grant to RI communities to implement strategies to address these risk and protective factors. In addition, twelve Partnership for Success communities receive funding to implement evidence based practices to reduce youth marijuana use and underage drinking through a SAMHSA discretionary award that ends in September of 2018. Changes in risk or protective factors are measurable within the time frame covered in this plan, either by existing pre or post-test surveys or the Rhode Island Student Survey.

1. Perception of risk or harm

A major shared risk factor for misuse of substances is low perception of risk or harm. To that end, funded entities are charged with focusing on **increasing the perception of risk of harm associated with chosen priority substance(s).**

RI vs. US Perceptions of Great Risk of Smoking Marijuana Once a Month by Age Group, 2007-2014
State Epi Profile – Figure 2.1.2.



Source: National Survey on Drug Use and Health (NSDUH)

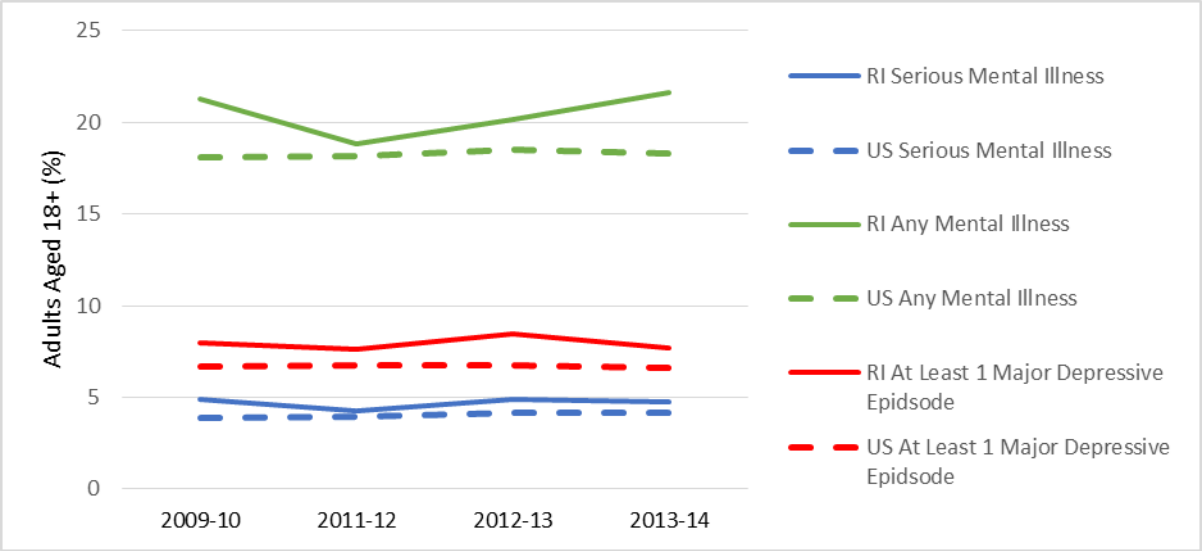
2. Access and Availability of Substances With Age Based or Other Conditional Use Restrictions

Use of alcohol and tobacco is restricted to adults, which is defined as 21 for alcohol and 18 for tobacco. Currently, marijuana possession and use is illegal in Rhode Island. In the case of medical marijuana, there may be some circumstances in which an underage individual has a medical marijuana card permitting possession or use of marijuana for medical purposes.

Other related risk or protective factors are derived from research literature or other reputable sources and can be targeted with funds based on departmental approval.

D. MENTAL HEALTH

RI vs. US Adult Past Year Mental Health, 2009-2014
2015 State Epi Profile – Figure 2.3.2.



Source: National Survey on Drug Use and Health (NSDUH)

RI fares worse than most states in the region across all adult mental health indicators including past year serious mental illness, past year any mental illness, and having had at least one major depressive episode in the past year. RI has consistently fared worse than the national average across adult mental health indicators. In 2013-14, RI had the highest prevalence in the northeast region for any mental illness in the past year (See State Table 2.3.3).

Efforts to include mental health promotion in the work of prevention coalitions and primary prevention efforts that also have positive outcomes related to prevention of suicide across the lifespan should be a focus.

SECTION 4 - ALIGNMENT WITH SAMSHA'S STRATEGIC INITIATIVES

The priorities identified through the 2015 State Epi Profile align well with SAMHSA's strategic initiatives, insuring that BHDDH and its' state and community partners are continually improving and refining capacity to address these issues across the state. In addition, focusing on workforce development, creating/sustaining state and community partnerships and improving/enhancing use of data guided decision making will poise RI well to leverage discretionary funding from SAMHSA to expand our reach.

*SAMSHA's 2014-2018 prevention goals include***:**

Goal 1.1: Promote emotional health and wellness, prevent or delay the onset of and complications from substance abuse and mental illness, and identify and respond to emerging behavioral health issues.

Goal 1.2: Prevent and reduce underage drinking and young adult problem drinking.

Goal 1.3: Prevent and reduce attempted suicides and deaths by suicide among populations at high risk.

Goal 1.4: Prevent and reduce prescription drug and illicit opioid misuse and abuse

BHDDH prevention priorities, which are consistent with SAMHSA's goals, most broadly reflect the following:

- Increase the capacity of the state's prevention workforce
- Support key stakeholders, prevention providers and policy makers to understand, promote and work towards preventing and reducing substance use across the lifespan
- Create an integrated prevention service delivery system which incorporates a broader behavioral health approach

It is important to reiterate here that BHDDH's goal of developing an integrated behavioral health infrastructure is an on-going process with a major transitional period occurring in 2016 as it implements a new prevention service delivery model. BHDDH's priorities focus primarily on workforce development and infrastructure to support the behavioral health priorities of SAMHSA.

SECTION 5 - STRATEGIC PLANNING GOALS AND OBJECTIVES

These strategic planning goals and objectives were developed based on input from the Prevention Advisory Committee (PAC), current EPI data and in context of an evolving prevention system revision process. The PAC held a series of four (4) strategic planning sessions during 2015 and early 2016 to help inform this Plan. The goals and objectives, provided below, prioritize infrastructure development, workforce development and reduction of key risk factors identified in the state's EPI profile. BHDDH's prevention goals are designed to foster and monitor the supports, collaborations, and systems needed to meet the desired outcomes related to reducing risk factors and promoting protective factors.

A. SYSTEM-LEVEL INFRASTRUCTURE DEVELOPMENT:

Goal One: *Develop and implement a substance use prevention and mental health promotion delivery system designed to support effective prevention initiatives and leverage cost and resource efficiencies.*

Objective I: By January 31, 2017, BHDDH will implement a new prevention service delivery model. (Please note: the RFP for prevention providers is currently under development. BHDDH will update this plan with specific objectives and measures once the new prevention delivery system plan can be made public.)

Goal Two*: Improve state and local of prevention provider's ability to integrate substance use prevention and mental health promotion across behavioral health provider systems.*

Objective I: By Dec 31, 2017 (and for each year after) BHDDH will document the surveillance of current providers for prevention and mental health promotion on the state and community level(s) to ensure contract deliverables are being met and document the integration of behavioral health across prevention initiatives through the production of an annual summary report presented to the PAC and to the Governor's Council on Behavioral Health. The summary report will document the integration of mental health promotion in substance use prevention initiatives across the following state and community level organizations:

a) State-level:
    1. URI, Statewide Evaluation Contracts
    2. State Epidemiology Outcomes Workgroup (SEOW)
    3. RI Prevention Resource Center (RIPRC)
    4. Evidence-based Workgroup
    5. Overdose Prevention Workgroup
b) RI Substance Abuse Prevention Act (RISAPA) Grantees
c) Marijuana and Other Drug Initiative (MOD) Grantees
d) Partnership for Success (PFS) Grantees
e) RI Student Assistance Service (RISAS) Grantee

Objective II: Maintain a consistent meeting schedule of groups addressing behavioral health issues. Each meeting will specifically identify opportunities to address the following: 1) to increase

communication across the sectors; 2) to identify increased opportunities for collaboration across sectors; 3) to ensure promotion of existing prevention services and initiatives and; 4) to document the integration of prevention and mental health promotion across behavioral health provider systems.

Meetings will include and meet as follows:

a) Governor's Council on Behavioral Health: Monthly
b) SEOW: Quarterly
c) RI Prevention Certification Board: Quarterly
d) RISAPA Grantees: Monthly (this may vary as this is a voluntary, provider-led group)
e) RIPRC: Monthly
f) MOD: Quarterly
g) PAC: Bi-monthly
h) PFS: Quarterly
i) RISAS: Quarterly
j) Evidence-based Practices Workgroup: At least quarterly
k) Overdose Prevention Workgroup: Monthly

Objective III: By July 31, 2017, BHDDH will update, based on recommendations from the evidence-based workgroup, data-driven, promising and evidence-based practice standards for all funded prevention providers in order to meet the requirements outlined in the strategic plan.

Goal Three*: BHDDH and/or a contracted provider will convene and staff the Rhode Island Prevention Advisory Committee (PAC), a committee appointed by and accountable to the RI Governor's Council on Behavioral Health.*

Objective I: By July 31, 2017, the PAC will recruit and maintain 80% of required representatives appointed by the Governor's Council on Behavioral Health and maintain a minimum of 15 professionals representing a broad range of content expertise, including but not limited to required representatives (*refer to list below*).

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

1) BHDDH Prevention and Planning Unit*
2) Department of Health (HEALTH) and/or Community Violence Prevention and/or Suicide Prevention *
3) RI Substance Abuse Prevention Act (RISAPA) *
4) Mental Healthcare
6) Certified Prevention Specialist*
7) Student Assistance Program *
8) State Epi Outcomes Workgroup (SEOW) *
9) Department of Youth and Family Services Prevention Specialist/Family Community Care Partnership Representative (s)
10) Military Prevention
11) School-based Healthcare

12) Community/School Health Educator (s)
13) Physical Healthcare Provider (s)
14) Parent Organizations
15) Law Enforcement
16) Tobacco Control Prevention Specialist (s)
17) Recovery and Treatment
18) Developmental Disabilities
19) RI Department of Education
20) Youth Organizations
21) Mental Health Promotion
22) Evidence-based Practice Workgroup

Please note: sectors followed by an asterisks (*) are required representatives and are appointed by the Governor's Council on Behavioral Health.

Objective II: The Prevention Advisory Committee will meet specifically to 1) review current prevention research; 2) review prevention policy updates; 3) develop new prevention policies (as needed); and, 4) disseminate quarterly meeting notes and action items; and 5) submit recommendations regarding prevention priorities and policies to Governor's Council on Behavioral Healthcare.

Objective III: By December 31st, 2016 (and for each year after), the Prevention Advisory Committee will assist BHDDH and the Governor's Council on Behavioral Healthcare to document the deliverables outlined in the RI Strategic Plan for Substance Abuse Prevention in a written annual report.

Goal Four: *Develop and document a plan to improve state and local cross organizational collaboration among funded providers who implement prevention initiatives. The plan will be designed to document the improvement of local, regional and/or state infrastructures to provide effective and inclusive behavioral health services.*

Objective I: By July 31, 2017, develop and implement a state-wide inventory of behavioral health prevention services, regardless of funding source.

Objective II: By July 31, 2018, develop and implement a state-wide inventory of data collected which may inform prevention efforts, regardless of funding source.

Objective III: By July 31, 2019, develop and implement a central, state-wide data collection repository of prevention data.

B. WORKFORCE DEVELOPMENT AND SUSTAINABILITY:

Goal Five: Identify standard core competencies and skills required to implement effective prevention initiatives.

Objective I: By January 1, 2017, establish a modified prevention service delivery system which includes a multi-tiered classification of prevention providers. The classification will be designed, in

consultation with the RI Certification Board, to acknowledge and document the varying levels of content expertise within the prevention service delivery system.

Objective II: By July 31, 2017, develop and disseminate a workforce development plan, which documents the criterion for a multi-tiered classification of prevention providers* and a plan to provide on-going professional development opportunities to increase the capacity of funded prevention providers.

***Goal Six**: Maintain and evaluate an effective substance use prevention and mental health promotion system.*

Objective I: By December 31, 2018 (and every year after), BHDDH will develop an annual report utilizing prevention data to analyze and report on process and outcome measures to determine the effectiveness of the state's prevention and mental health promotion system and to make recommendations for improvement.

Objective II: By December 31, 2019 (and every year after), BHDDH will develop and/or update a sustainability plan to specifically outline prevention and mental health promotion programming, policies and initiatives.

Objective III: By July 31, 2018, develop and disseminate a suite of training and performance monitoring tools to guide on-going prevention program improvement.

***Goal Seven**: Based on the current available behavioral health data, BHDDH will monitor processes to improve outcomes across prevention and mental health promotion programs.*

Objective I: By July 31st, 2019 increase the number of funded substance abuse prevention providers who are active (not expired or newly hired) who are credentialed at the level of Certified Prevention Specialist or above from 32% to 75%

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

Objective II: By July 31, 2016 (and for each year after), BHDDH will ensure the RI Prevention Resource Center and funded prevention providers will collect data, report data, and identify data-driven program planning in reporting accordingly:

RISAPA Grantees: Monthly Reporting
MOD Grantees: Quarterly Reporting
PFS Grantees: Monthly Reporting
RIPRC: Quarterly Reporting and Annual Report
RISAS Grantees: Monthly Reporting

Objective III: BHDDH, through a training and technical assistance contract, will provide a minimum of 10 on-line or face-to-face trainings and a minimum of 100 technical assistance (TA) contacts annually.

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

Objective IV: Between January 1 and June 30, 2017, funded prevention providers will assess local needs, resources and readiness and develop a plan to reduce the impact of at least one of the state identified priority areas (presented below and in Section 3 of this plan). Funded providers will utilize State and local data to inform these data-driven programmatic planning, implementation and evaluation activities.

Objective V. By July 31, 2019, 80% of funded substance use prevention providers will engage representatives from the following six sectors:

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

Objective VI: After January 1, 2017, funded providers will address a minimum of one of the following priorities based on the results of the municipality's needs assessment and regional strategic plan:

(Selection of these priorities will be driven by local data and planning activities that align with SAMHSA and BHDDH priorities and set requirements.)

- 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).

Goal Eight: Funded prevention providers will measure and document two outcomes associated with BHDDH's prioritized risk factors.

Objective I: Between January 1st, 2017 and December 31st, 2019, funded entities should increase the perception of risk of harm associated with the chosen priority substance by 10% among the target population.

Objective II. Between January 1st, 2017 and December 31st, 2019, funded entities should reduce the access or perceived ease of access among populations for whom possession, use or consumption is illegal by 10% among the target population.

SECTION 6 - SUMMARY and CONCLUSION

BHDDH will use the strategic planning goals and objectives from Section 6 (Strategic Planning Goals and Objectives) to address the priority problems identified in the 2015 State Epidemiological Profile. While the Department strives to reduce the number of individuals who meet diagnostic criteria for substance use disorders, it is unlikely that the current primary prevention resources will have sufficient reach or intensity to produce a measurable change during the time frame covered in this strategic plan. BHDDH will measure change in the positive direction with risk or protective factors targeted within communities or regions on magnitude of 10% over baseline along a similar three year cycle among those populations, again where there are available data to measure change at the community or regional level.

By focusing on the integration of substance use prevention and mental health promotion across the State's behavioral health system, BHDDH is developing a stronger infrastructure to leverage efficiencies and opportunities for increased coordination, collaboration, and sustainability. Rhode Island's behavioral health system, including the collection of data used to measure and monitor substance use prevention and mental health promotion at the municipality level (or sub-State geographies), is an on-going process. BHDDH is taking important steps to cultivate its infrastructure to develop, maintain, and ensure a solid foundation for prevention work moving forward.