RHODE ISLAND
prevention resource center

Rhode Island Prevention Resource Center (RIPRC)

Year Two: August 1, 2013-July 31, 2014

Annual Summary

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Rhode Island Prevention Resource Center (RIPRC)
Training & Technical Assistance Summary

Year Two: August 1, 2013-July 30, 2014

The focus of Year Two of the Rhode Island Prevention Resource Center's (RIPRC) contract was to build upon and increase optimization of the infrastructure of the center. RIPRC Focuses on the implementation of a multifaceted TTA approach to support community-based, environmental prevention interventions, the implementation of evidence-based prevention programs and practices, and the development of a well-trained substance abuse prevention workforce. TTA was provided in five modalities: 1) Individualized/Organizational-specific TTA; 2) Learning Collaborative sessions (LC); 3) Content-specific Training; 4) riprc.org, a website for sharing resources and promoting training sessions; and 5) Collaboration with other TTA Providers.

Section A: Training and Technical Assistance (TTA) Overview

Modality 1. **Individualized/Organization-specific:** All TTA provided in Year Two was based on the 2012 TTA needs assessment data and proactive requests from community prevention providers and BHDDH.

Over the second year (2013-2014) the RIPRC provided TA based on proactive, individual requests received through the RIPRC TA request form (s) and/or direct requests via riprc.org contact us form, e-mail, by phone, and in-person.

RIPRC communicated directly with BHDDH and prevention partners to better understand their specific TA needs. The RIPRC provided TA services to 49% of the funded coalitions in addition to twelve (12) non-funded community, state and regional prevention providers.

Additionally, RIPRC staff participate in contract meetings with BHDDH twice a month, bi-monthly RISAPA meetings, quarterly Marijuana and Other Drug (MOD) Initiative grantee meetings, monthly Ocean State Prevention Alliance (OSPA) meetings, monthly Governor's Council on Behavioral Health (GC) meetings, and quarterly Prevention Advisory Council (PAC) meetings to continually assess TTA needs of the Rhode Island prevention community. An aggregate breakdown of the number, mode, and type of TA is provided below in Table 1.

Table 1: Technical Assistance Provided by the RIPRC, August 2013-July 2014

Unique Community Coalitions Served: 17 of 35 or 49%	**Total TA Services:** 105 Phone, E-mail, In-Person Meetings, & LC session(s)*	**Examples of TA Content**	**Unique Community/State/Regional Resources Served:** 12	**Examples of TA Content**	**Total TA Services:** 94 E-mail, Phone & In-Person Meetings**
Tiverton*	3	LC: Sustainability; MOD quarterly report templates	RI Student Assistance	Cross promoting training sessions	4
Foster/Glocester	12	Locate model programs for working with indicated/selected population in a rural high school	RI Department of Health	Substance abuse/use data sources	8
Narragansett*	2	LC: Sustainability	Youth Pride, Inc. of RI	LGBTQ specific Substance abuse/use prevention resources	1
North Kingstown	4	Certification test preparation resources	RI Governor's Council of Behavioral Health	Sharing PAC updates	5
South Kingstown*	2	LC: Infrastructure	University of RI	Review survey questions	3
Barrington*	12	LC: Sustainability	BHDDH	Contract meeting updates	52
Providence	4	Certification requirements and test support	RI Prevention Certification Board	Certification test preparation content	2
Chariho*	18	LC: Sustainability	AIDS Project RI	Connecting substance abuse prevention with sexual health issues	4

Block Island	1	Options for LC sessions		RI Substance Abuse Taskforce Association	Updates and promotion of RIPRC deliverables	5
Portsmouth	5	Help identifying evidence based marijuana prevention programs		OSPA	Data subcommittee resources	10
Johnston	6	Help finding the most recent National Survey on Drug Use		Community Action Partnership of Providence	TA assessment meeting	6
Central Falls	2	Certification requirements and test support		Tobacco Free Alliance	Opportunities for collaboration	4
Middletown	4	Accessing on-line training		***Includes: NEISAS, CAPT, SEOW, GC, PAC, MOD*		
Cumberland/ Lincoln	5	RISAPA facilitation support				
Jamestown	3	Marijuana edible resources				
East Providence	4	Scholarships opportunities for training				
Scituate	1	Policy resources				

Innovative TA:

The RIPRC receive a request from the Community Action Partnership of Providence (CAPP) to provide an in-depth TA session to increase the workforce capacity of frontline staff. A full day TA retreat was planned and implemented. The goal and focus of the retreat was to increase communication skills capacity, cultural competence in communication and building rapport while keeping boundaries and integrating prevention messaging and resources. Twelve participants completed the training. In addition to achieving the intended goal, several positive unintended outcomes occurred as part of the planning process. CAPP services a variety of middle and low income residents including senior citizens and pregnant and parenting teens. CAPP addresses many of social determinates that increase risk for substance misuse, mental health challenges and risk taking behaviors. Job and education readiness, food assistance, transportation, mental health services, home ownership and housing support services provide multiple opportunity to integrate prevention messages into existing service delivery, examples include:

- Assessing if older adults or seniors have medical marijuana cards or are caregivers to card holders
- Increasing access to substance use and mental health screenings via multiple entry points
- Increasing staff cultural communication skills to ensure messages are heard
- Free condom access to reduce multiple teen pregnancies
- Information about prescription drug misuse

Modality 2. Learning Collaboratives (LC): Learning Collaborative sessions were selected as a TA tool as they lend themselves to a more in-depth TA process which includes three sessions over approximately six months. The sessions included the *Prework Phase*, identifying the TA needs of the group which includes face-to-face or phone assessment calls and sample agendas were then provided, based on the discussion, for approval. Next the RIPRC implements the *Learning Sessions* which focus on the *What* and the *How*. The *What* entails education about a specific topic identified by the prevention providers. Groups develop measurable and achievable action plans for change with the support of peer learning teams and the RIPRC staff. Documentation outlining each component of the LC was provided and distributed to LC participants. *Action Periods* are when the work is implemented between learning sessions and provide opportunities to practice and implement newly learned content and knowledge gained during the learning sessions. An action plan was developed in session one of the LC and becomes the basis for the two consecutive sessions.

In Year Two, the RIPRC implemented LC sessions in five (5) communities, Tiverton, Narragansett, Barrington and South Kingstown. Tiverton completed session three (3), Narragansett session two (2), Chariho completed all three (3) sessions and Barrington completed session one (1) and two (2). All four of these communities focused on sustainability. South

Kingstown completed session two (2) and focused on infrastructure development. Two additional communities expressed an interest in participating in a LC in year two, these included: Portsmouth and Scituate. Sample LC action plan steps include:

- Coalition members complete a skills matrix and will update matrix twice a year
- Expand existing substance abuse prevention policy for high school to include synthetic marijuana- review policy annually and update to include emerging substances
- Recruit for missing sectors and revisit coalition membership twice a year
- Add sustainability as an on-going agenda item
- Meet with town council to add coalition as funding line item, ask twice a year
- Research non- traditional funding opportunities e.g. arts, gardening, policy

Modality 3. Content-specific training:

At total ten (10) training sessions were offered in Year Two, five (5) face –to face and five (5) e-training sessions. RIPRC partnered with RI Student Assistance to offer two training sessions in one day: SBIRT and LGBTQ Positive!. RIPRC also offered Preparing for the Prevention Certification, Focus Group Development and How to Use Local Data training sessions. RIPRC collaborated with CAPT to implement online courses: Ethic in Prevention (twice), Hiring an Evaluator, Data Collection Methods Getting Down to Basics and What Now? Creating an Effective Data Presentation.

Twenty one (21) unique prevention providers participated in the in-person training sessions and the evaluation findings are provided in Appendix III of this report. RIPRC provided a total of fifty six (56) hours toward Prevention Certification for prevention providers. Forty one (41) unique organizations participated in face-to-face training sessions in Year Two. Table 2 lists the twenty two (22) prevention communities and the nineteen (19) participating organizations.

Table 2: In-Person Training Attendee Organizations

Participant Organizations		
Burriville Coalition	Block Island	RI Department of Education
Central Falls Coalition	Chariho Coalition	Youth Pride
Johnston Coalition	Portsmouth Coalition	Cumberland Public Schools
Portsmouth Coalition	Warren Coalition	Chariho Regional Schools
Narragansett Coalition	Lincoln Coalition	Warwick Public Schools
Tiverton Coalition	Pawtucket Coalition	Pawtucket COZ
Bristol Coalition	Bay Team/Barrington Coalition	Westerly Public Schools
East Providence Coalition	North Kingston Coalition	Health Community Office
Central Falls Coalition	Meeting Street	Rockwell School
Newport Coalition	Pawtucket Adult Education	North Providence Public Schools
Situate Coalition	BHDDH	Providence Public Schools
Smithfield Coalition	Cumberland Public Schools	RI Department of Health
Middletown Coalition	Lincoln Public Schools	EWG Prevention and Wellness
Warwick Coalition	RI Student Assistance	

Participation in learning opportunities increased the capacity of the RIPRC staff and collected additional resources to share with other providers. RIPRC staff participated in the CADCA Mid- year Conference, in July 2014. Staff also participated in the SAPST VTOT in September 2013 and the New England School of Addiction Studies in June 2014.

Modality 4. Developing and Maintaining Website/Resource Sharing:

The project website, riprc.org, is one aspect of a broader communications strategy. The project communications plan helped improve the consistency and impact of project approach in order to enhance the overall performance of the project. The website communications plan provided a guiding framework for the RIPRC website development, maintenance, evaluation and optimization. The riprc.org optimization strategy was also informed by planning meetings with BHDDH, provider feedback and RIPRC team brainstorming sessions around website related communication efforts, goals, and actions in relation to overall project goals.

Website Development Details:

As part of the riprc.org optimization and private platform development, we operated upgrades in the JSI IT environment to allow the site to be fully responsive to the development of the secure private platform or

RIPRC Provider Portal. We put in place the necessary plugins and coded features to be able to customize the online community of practice to fit providers' needs and security protocols. Finally, we developed several databases to improve content search; created functionality that allows for and promotes user content uploading and interaction; and modified general navigation and design to allow for easy user navigation between the two platforms (public and private platform i.e. RIPRC Provider Portal).

In total we optimized three main features of the public site (info center, prevention provider listing, and calendar), and created six main features of the private site (registration/login, forums, provider planner, member list/profile, resource library, and notifications/site- wide activity) as well as navigation between the two platforms.

- **Resource sharing** (two-way): Being a clearinghouse of existing prevention resources (local, state, and national) for providers, and have providers share resources with the RIPRC to disseminate.
- **Data Sharing**: To house a library of data resources (for use in grant/funding applications and to inform programmatic efforts)
- Build relationships and **collaboration** in the prevention community (and by doing so reduce silos)
- Demonstrate **the continuum of prevention** (providing resources beyond substance abuse prevention to include other public health issues, such as: violence prevention, suicide prevention, and other interfacing preventions)
- Community and partner **recognition** (highlighting what's going well in the community)

The website also aimed to:

- Introduce RIPRC (as a new resource for the prevention community)
- Demonstrate that BHDDH has invested in the concept of a prevention resource center, and act as a place to provide BHDDH prevention updates
- Mirrors the Project Strategic Plan (and/or Training and Technical Assistance Plan)

The targeted audiences for riprc.org include: prevention providers, health educators, community coalition members, BHDDH, parents/caregivers and broader community members who may not be engaged in prevention, but have an interest.

A six month digital analysis (based on google analytics data) is provided in Appendix IV of this report. RIPRC staff produced, tested and sent the RIPRC eNews every 6-8 weeks since the launch of riprc.org, six (6) were sent in Year Two. The newsletters highlight local partners

innovative work, training opportunities, new web resources, and the TTA provided by the RIPRC. RIPRC staff continue to develop much of the original content for the website as well as educational tools, including five (5) new topical prevention factsheets in Year Two. RIPRC staff also actively maintain an event and training calendar on riprc.org.

Modality 5. Collaboration with other TA and Training Providers

The RIPRC participates on numerous prevention groups including:

- SEOW
- RISAPA
- ICRC Certification Board (non-voting member)
- New England School of Addiction Studies, Planning Team
- CAPT, Planning and Peer Sharing Committee
- Governor's Council on Behavioral Health (non-voting member)
- RI HIV Prevention Coalition
- Marijuana and Other Drug Initiative grantee meeting
- Ocean State Prevention Alliance
- Tobacco Free RI Provider Network

As a component of the RIPRC's collaboration with BHDDH, the RIPRC also reviews and summarizes the Marijuana and Other Drug Initiative grantee reports quarterly to facilitate BHDDH's review and makes data quality recommendations.

BHDDH requested a revision of current 2010-2015 RI State Prevention Strategic Plan to be conducted by the RIPRC. A draft of the revisions was provided to BHDDH in July 2013 with draft goals and objectives and a request for BHDDH to clarify expected measures for defining success and additional feedback as needed. The Plan was edited and approved in October 2013 and posted on riprc.org. The RIPRC also submitted a draft Workforce Development Plan to BHHDH for review and feedback in May of 2014. A copy of the draft plan is provided in Appendix V of this summary.

In an effort to fully integrate prevention into the state's behavioral health system, RIPRC recommended that the Governor's Council on Behavioral Health (GC) implement a Prevention Advisory Committee (PAC) as a formal committee to the council. The proposal was approved by the GC and the PAC has met two times in Year Two. A description of the PAC and PAC meeting minutes are provided in Appendix I.

BHHDH, in response to community requests, asked RIPRC to facilitate community meetings to address concerns about potential regionalization of prevention services. The meetings have since evolved into a community discussion regarding funding and additional service delivery options. Meeting notes are provided in Appendix II.

In Year Two, the RIPRC was able to expand and build upon the infrastructure for service delivery developed in Year One. The RIPRC continues to optimize, promote and maintain the riprc.org website and improve it through the development of the password protected platform to be released in Year Three; to build strong collaborative relationships both local and state-wide; implement TA services and training; and to plan and promote additional training opportunities. A second TTA needs assessment will be implemented in Year Three.

Section B: Related Appendices

I. Prevention Advisory Committee (PAC) Minutes

II. Regionalization/Community Meeting Notes

III. Training Agenda and Evaluation Results

IV. Riprc.org Six Month Digital Analysis Report

V. Workforce Development Draft Plan

I. Prevention Advisory Committee Minutes

Governor's Council on Behavioral Heath's Prevention Advisory Committee
April 15, 2014; 10AM-12PM
BHDDH Barry Hall; Room 226

Introduction: (Sandra and Shannon)

- Chairperson: Sandra Del Sesto
- PAC is a permanent committee on the Governor's Council for Behavioral Health.
    - Governor's Council is statutory.
    - Governor's Council is broader than BHDDH that includes many state agencies, providers and consumers of behavioral health services.
- PAC is planning to meet 4 times a year.
    - Are 4 meetings a year enough to meet the goals of the PAC? This can be discussed. The reasoning behind this was that everyone already has a lot of meetings to attend and that work could be conducted more efficiently in sub-committees as needed.
- Goal of PAC is to make recommendations to the council that will go into the annual report to the Governor and to the federal government's block grant. (Further information on this is presentation in the binder.)
    - **ADD**: Strengthen and expand the prevention workforce in Rhode Island

Group's Goals for the PAC: (All)

- Expand prevention beyond substance abuse prevention
- Integrated partnerships of prevention – in particular in funding and resource collaboration
- Bigger picture of prevention
- Be able to reach populations that have been hard to reach
- Improve data collection systems in Rhode Island; integrate systems for better evaluation
- Work on integrating silos (SAMHSA)
- Prevention within the roll-out of ACA and EOHHS
- Work to eliminate health disparities
- Reduce stigma around mental health and substance abuse disorders

- Increase availability of risk/harm reduction systems
- Systems that affect individuals, families, communities
- **Coordination and integration across departments, integrating different aspects of prevention**
- **Improved data gathering**

Formation of the PAC: (Shannon)

- Was created as a part of the Governor's Council in order to institutionalize it
- Exciting to get everyone around the Governor's Council table talking about prevention

Prevention Overveiw (Sandra)

- "Preventing Mental, Emotional and Behavioral Disorders Among Young People" NIH and IOM Book summarizing prevention practice up until this point.
- Many risk and protective factors overlap between prevention fields: teen pregnancy, child abuse, depression, suicide, SA
    - Where those overlap is where we have commonalities
- Promotion messages are the same universally in the health field- diet/exercise, healthy self-image, positive relationships, etc.
- Prevention is more specific to a particular disorder/health outcome
    - Universal: affects all populations regardless of risk
    - Selective: affects high risk populations because of their situation (family substance abuse, socio-economic deprivation)
    - Indicated: affects persons who have begun to engage in high risk behaviors but don't yet need treatment
- Treatment and Maintenance: Becomes more specialized and more expensive. Potential opportunity to have treatment side refer back to the prevention side.
    - ACA funds 2 "prevention" initiatives- tobacco cessation and SBIRT
- Important to understanding the "Public Health Triangle" to speak the same language as non-preventionist, public health professionals
    - Frogs(host) get sick in the pond(environment). Blame the frog(host) or blame the pond(environment)? Stigma has you blame the frog.

State Strategic Plan (Charles)

- In 2004, EOHHS received a five year grant for strategic plan framework. As a part of that work, began to look at information gathered about local communities, counties, state around substance use. At the end of the grant period, created a 5 year sustainability, strategic plan for prevention. Strategic plan for prevention was brought to prevention advisory group (BHDDH and RIDE) and to Governor's Council. Plan was meant to be amended over time.

Status of Prevention Initiatives in RI

- BHHDH: 35 tasks, RISAS (7,000 students), Partnership for Success Grant (Underage Drinking, Marijuana, Prescription Drug Use and Abuse; 12 communities; 2 employees starting May 5; 5 year grant); Marijuana and Other Drugs (5 Communities); RIPRC; SEOW (Manages, Collects and Analyzes Data); FDA Monitoring Program; Underage Drinking Enforcement

- HEALTH: Violence and Injury Prevention Team (Falls prevention, MVC, Rape Prevention, Suicide Prevention, Tobacco; all funded federally), Center for Health Data and Analysis (a lot of data available, YRBS, Violent Death), STD/HIV Prevention

- DCYF: Children's Administration, SAMHSA, Chadwick Center for Trauma, BrightStars, Post-adoption funding; prevention has historically viewed as prevention of abuse or prevention of intervention needed by the department; Have now begun to look at child maltreatment reports that have not required an investigation but looking at domestic violence, substance abuse, familial crisis. Now refer families into the community which has decreased re-child maltreatment rates. Have seen an uptick in substance abuse (opiate, prescription and non-prescription abuse); 4 FCCPs (Family Community Care Partnership) across the state create informal care plans, need more outreach to parents/families, have an advisory group. Have switched from a case management model to a wrap-around model.

    - Send info about the local FCCPs to Shannon.

- ***For next meeting: agencies provide a summary about prevention activities at their agency***

Most Pressing Prevention Issues in Rhode Island: (All, in small groups)

- Youth perception of harm. Need to have a clear public health message.

- Equitable distribution of prevention resources, including all systems

- Better integration of mental health, substance abuse, physical health and academic services

- Need for improved data collection

- Funding

- Topic specific issues: Prescription drug/opiate overdose, marijuana legislation, RBS and fake IDs, Alcohol-related crashes, underage drinking

- A focus on prevention: increase/improve universal public education messaging around perception of harm , specifically targeting marijuana and prescription drug use/abuse
- Early identification of problematic substance abuse in youth and pre-natal
    - This issue is very sensitive in how to operationalize as to not label or stigmatize
- Behavioral health disparity as a priority
    - No current survey allows for identification of where the disparity lies; we need to become research based as opposed to assumption based
- Overdose

NEXT MEETING: August 5, 10AM-12AM- Focus on local, current data

- ***Agencies Provide a Brief Summary of what is going on in Prevention***
- Recommendations for further sector nominations: Family Court, DOC, RI Hospital Injury Prevention, Enforcement, AG's Office, Labor and Training, Healthy RI out of Lt. Gov's Office

II. Regionalization/Community Meeting Notes

Activity description: Meeting with Rhode Island (RI) community prevention providers facilitated by JSI Research and Training Institute, Inc. (JSI) on behalf of the RI Department of Behavioral Healthcare, Department Disabilities and Hospitals (BHDDH).

Notes developed by Beth Beatriz and Ann Marie Rakovic, JSI

Date: April 2, 2014, from 1-3PM

Location: Warwick Public Library

Participants: See attendance sheet for list of 18 prevention providers, Charles Williams, Elizabeth Kretchman and Anna Meehan from (BHDDH) and Beth Beatriz (note taker) and Ann Marie Rakovic (facilitator) from JSI.

Background: At the request of the BHDDH, JSI was asked to facilitate a meeting with community substance abuse providers with the following objectives:

1. To engage community prevention providers in the first in a series of discussions about helping to shape the concept of a regional prevention service model in Rhode Island.
2. To understand issues and to garner suggestions and recommendations from community prevention providers regarding regionalization planning.

An agenda was developed by BHDDH and JSI and shared with the invited participants the day before the meeting.

At the start of the meeting participants were invited to introduce themselves and speak briefly about their hopes for what they might get out of the meeting. They were also invited to use the prepared agenda as a guide to structure the meeting however they were also given the option to co-create the agenda for the day based on their needs and interests. The prepared agenda was loosely followed. Notes to discussion were recorded on newsprint for distribution to the participants after the meeting.

Newsprint Notes:
This section aims to capture the ideas, comments, hopes and concerns shared by the community partnerships funded by the BHDDH during the discussion on potential regionalization. Ideas have been sorted into thematic categories, which do not necessarily reflect the order in which they were discussed. Items which were emphasized by providers/BHDDH have been <u>underlined</u> throughout the document.

1. **Prevention Providers' Hopes for Meeting:**

- <u>To be a part of the discussion and planning process:</u>

- To understand meeting participant's opinions and ideas regarding the possibility of regionalization.
- To provide input into making regionalization effective/beneficial if it is going to happen and to help to minimize any drawbacks.
- To see a community involvement process occur which is not department driven.
    - To have provider voices heard.
- To advocate for a local level prevention framework.
- (Providers' ask) Why regionalize?
- To identify the best delivery model(s):
    - Providers have an opportunity to help plan the regionalization effort with enough time and thought. The planning should consider all elements of prevention (example Student Assistance, etc.)
    - RI's small size should be seen as an asset.
- To begin to understand what regionalization would mean for each town (and the whole state).
    - Ramifications around funding, legal issues and responsibility changes need to be considered.
    - Understand the political environment surrounding prevention and regionalization.
- To gain guidance and perspective.
- To keep prevention first in the regionalization discussion.
- To share lessons learned from past experiences with regionalization- challenges and efficiencies.
- To identify any changes in the role of prevention providers after regionalization. (For example, will there be fewer providers?)
- To formalize "informal" network of providers.
- To understand the political environment surrounding prevention and regionalization.
- To be aware that one gets out of the process what they put into it in terms of desires and contributions.

2. Providers Concerns about Regionalization:

- Does regionalization really mean "funding cuts?"
- Role of prevention providers after regionalization. Will it mean fewer providers?
- Concerned about day-to-day structure, structure of regionalization.
- Concerns about becoming too big and too regionalized and then losing funding
- Providers fear loss of their jobs. Some providers believe however that fear still shouldn't stop the discussion if it can improve things.

3. BHDDH Overview provided by Elizabeth Kretchman:

- History of regionalization: BHDDH proposed a regionalization program that was rejected by the provider community several years ago. It didn't move forward because of concerns from the community and from providers.
- This time around, providers have brought the idea forward as an informal suggestion.
    - Clarification from providers: The discussion held between BHDDH officials and providers was about how to make prevention effective and sustainable, not necessarily about regionalization.
- It is up to the provider group as to whether or not regionalization goes forward at this point and what that would that would mean. Providers can guide the process.
    - The process will be a participatory decision making opportunity where all providers will have forums available to have their voices heard and considered by BHDDH.
- BHDDH has made no plan or decisions about regionalization efforts or funding changes at this point.
- BHDDH hopes that this will be the first of many discussions.

4. Key Questions asked by Providers:

- What is the best prevention model for RI?
- How is prevention funded in RI? (Including all the moving parts- RISAS and BHDDH)
    - Charles Williams, BHDDH, provided verbal information on funding for specific projects and included Block Grant information that needs to be re-capped in writing for the group.
    - BHDDH committed to making prevention funding information available and to consider providing an organizational chart or other matrix to easily identify

        - Which programs receive funds,
        - Where programs fit under BHDDH organizational chart,
        - How much money is received,
        - Funding sources, and
        - Services provided.

- Where do providers fit? What are provider and BHDDH roles in the decision making process?
- Prevention providers feel as if they are not seen as a priority within BHDDH.
    - Providers want transparency between the funders and coalitions, prevention and treatment providers.
- What is the BHDDH motivation behind the regionalization discussion?
    - Is it to try to sustain current services and programs, to downsize or to grow?
- The more important question than regionalization is - How can we better advocate for prevention?

5. Provider thoughts on what regionalization means?

- There is a need for a common definition. It was noted by the facilitator that the meeting was not set up to present proposed models at this point.
- Community collaborations are the most effective prevention measures.
- Potential for restructuring of staffing, funding, resources, communities/catchment areas, and approaches to service delivery.
- A needs assessment would need to be conducted detailing funding sources and what they cover.
- BHDDH structure may need to change as well in order to manage resultant changes in programs.
- Improved efficiency
    - Potential to pool funds to have projects that are more effective. (i.e. Media campaigns)
- Elimination of redundancy
- Improved quality
- Fewer staff doing more work.

- Have to deal with who takes on responsibility for what is "lost" in regionalization?
- Ability to partner with similar communities, potential mentorship between stronger cities/coalitions and mentees. (Not regionalization, but ability to pool funding)

6. What is regionalization going to look like going forward?

- Currently, BHDDH does not have a plan for what the regions are going to look like. The hope is that prevention providers will offer suggestions.
- There are as many regionalization models as there are states. We need to look at them as examples, but will need to create the best model for RI which most likely be a customized/hybrid.
- Prevention providers are interested to look at other models for education, inspiration and/or adaptability for RI.
- CADCA may be a resource to coalitions through this regionalization discussion/process. .
    - What does CADCA's data say are essential to coalition success? (Including but not limited to funding, certification)
    - Leadership training may be available as well as technical assistance in topical areas.

7. Next Steps

- Providers suggested taking a step back and asking, "What is the best model for prevention service delivery?"
- Providers thought that it would be helpful to have "Best Practices for RI" set of service standards available to coalitions and prevention providers. They noted that while communities are different, some general guidelines are universally applicable.
- Elizabeth Kretchman, BHDDH was designated as the point person for providers to contact with any feedback from the meeting.

8. Future Meetings:

- Providers suggested that there be de-briefing meeting next to review the environment that they are currently working in. They would like to see a funding/services list and an, organization chart from BHDDH.
- Proposed date for an in-person follow-up meeting is May 7th from 1-3pm.

- Providers would also like to consider other states' prevention delivery models to begin to understand the similarities and differences between RI and other states.

Activity description: Notes to meeting with Rhode Island (RI) community prevention providers facilitated by JSI Research and Training Institute, Inc. (JSI) on behalf of the RI Department of Behavioral Healthcare, Department Disabilities and Hospitals (BHDDH).

Notes developed by Beth Beatriz and Ann Marie Rakovic, JSI

Date: May 7, 2014, from 1-3PM

Location: Warwick Public Library

Participants: See attendance sheet for list of 16 prevention providers, Charles Williams and Elizabeth Kretchman from (BHDDH) and Beth Beatriz (note taker) and Ann Marie Rakovic (facilitator) from JSI.

Purpose of meeting: The aim of this meeting is to review the priorities set forth at the first community discussion forum to address the possibility of developing a regionalization plan for prevention programs.

Review of ground rules for the meeting: BHDDH is committed to an open communication process. In order to foster free discussion and encourage collaboration, "ground rules" for the meeting were reviewed which included: raising hand to speak, no cross talk, turning off electronic devices, being self-aware of "air time", and tabling issues that are not on topic or are too detailed and can be addressed later.

Review of planning call held for this meeting:
On Friday, May 2nd, in response to an invitation by BHDDH to all prevention providers, five providers (Lisa Carcifero, Nancy DeNuccio, Peter Asen, Ray Davis and RebeccaElwell), volunteered to join BHDDH and the meeting facilitator (Ann Marie, JSI) for a conference call to plan the May 7th agenda. Participants also reviewed the minutes from the prior meeting. The volunteers responded to an invitation to participate sent to all providers to insure all of the needed information was included. A few key notes from the planning call were shared:

- Peter Asen asked that we consider how those who are not able to attend these communication forums might still be able to contribute their feedback and ideas.
    - Suggestion: Send out minutes to all and allow people to comment on the minutes and then re-send them out with annotations incorporating feedback/suggestions.
- Nancy DeNuccio suggested that full collaboration would be needed on a variety of issues that the group is discussing.
    - Suggestion: Flag topics in the minutes that need everyone's thoughts.
- Everyone agreed that we needed to have firm dates for future meetings.

- Suggestion: Set possible options now for June, July and August dates and send out a follow-up schedule Doodle to everyone. Proposed dates/times are included in the "Next Steps" section of these minutes. A doodle has been created to identify meeting dates.

Review of last meeting minutes:

- Participants agreed that the minutes captured very well a discussion that was somewhat confusing.
- Suggestion: Attach the sign-in sheet, add Anna to participant list and re-send edited minutes to all.
- Participants agreed that the documents that were provided by BHDDH in advance of the May 7th meeting were exactly what were asked for by providers on April 2nd. However it was noted that the funding chart distributed is only as complete as the information that BHDDH has available.
- The following question was asked: What is the end goal of these community meetings with BHDDH?
  - Betsy clarified that the meetings were initiated to provide a forum for all providers to discuss the possibility of planning for a move to regionalization of prevention programs as a means to optimize prevention service delivery - however given the participant feedback in April the meetings have now been re-focused to serve as an interactive way to for prevention programs to share approaches toward collaboration opportunities that may not be as formal as regionalization planning.

Small Group Activity: Prioritization

In order to set a focus on the continuation of these BHDDH/provider meetings, providers were broken into groups of four and asked to rank the top 3 priorities from the list below (based on interests shared in the previous meeting):

1. Investigate best **prevention service delivery models**
2. Explore relevant **regionalization models,** define regionalization
3. Review current and planned **community collaborations**
4. **Map current funding levels** and services by coalitions across the state
5. Conduct **needs assessment** of services/gaps/needs
6. **Map BHDDH Strategic Plan** for Substance Abuse Prevention onto current services
7. Receive **training/technical assistance** to enhance performance and leadership
8. Other (write in)

Results

Priorities (Highest-7 Lowest)

1. Map current **funding levels and services by coalitions** across the state
2. Investigate **best prevention service delivery models**
3. [TIE]Review current and planned **community collaborations**
3. [TIE] Map BHDDH **Strategic Plan** for Substance Abuse and Prevention onto current services
4. Explore relevant **regionalization models**, define regionalization

Proposed Funding Matrix Ideas:

A discussion was held regarding interest to develop a funding matrix outline that would need to be completed by both BHDDH and the prevention providers. This process has already begun with one of the RISAPA coordinator's sending out an excel document to each coalition to collect information on how much each is spending on Student Assistance. The following conclusions were made:

BHDDH has information on how much funding each provider receives and how many counselors are available in the schools. BHDDH does not however currently have access to information about how much total money is in the Substance Abuse Counselors (SAC) system given providers have other contributing sources for funding (RISAPA, for example). In order to have a full understanding of the SAC funding and resources available in the various communities around the state, BHHDH would need to find out the total number of SACs split across all schools by number of days/hours available weekly per school. BHDHH has agreed to figure out how to collect this information.

The following list reflects ideas generated at the meeting to be considered for inclusion in a funding matrix. Please note that the original criteria outlined below was developed in reference to the (SACs), and the criteria was later thought to serve as a potential template for other areas of prevention services:

Funding Matrix Variables:

1. Amount of funding received
2. How funding is allocated at the community level (communities/neighborhoods, coalition, school districts)
3. Description of work that SACs are performing, Are they evidence based activities with proven outcomes?
4. Other programs in communities that target youth prevention
5. Total number of Middle Schools (MS)
6. Total number of High Schools (HS)

7. Number of MS SAC days/hours funded weekly (or other areas of interest, i.e. coalition coordinator)
8. Number of HS SAC /hours funded weekly
9. Total amount of BHDDH funding for SACs
10. Amount of coalition funding for SACs
11. Other sources of funding for SACs
12. Amount of time coordinators are funded
13. Is coalition or funded entity a designated non-profit 501c3?

Summary notes from community presentations:

I. Student Collaboration by Communities: Chariho

Have collaborations between coalitions *and* collaboration within the community.
Community collaborations tend to be more difficult.

- RISAPA provides partial funding for SAC and the schools pay the other part. Need to continuously work with the schools to make sure they honor their part of the funding.
- Work with police departments: tribal police, state police and environmental police. Police mandate that some funds go back to the task force.
- Also work with collaboration through services.

Coalition collaborations:

- Trainings that are offered to several communities
- Work together to bring presenters/presentations to the town
- Positive community norms training. Normally in Montana, but they will be coming to RI that will be offered to RI coalitions for a minimal fee.
- Corkery House comes to schools to talk to 7th and 8th graders about positive decision making. This has spread to other communities' schools. Has been expanded to the high school. Cranston is having it is part of their prom message assembly.
- OSPA been an area of collaboration for creating a united front and sharing resources related to Marijuana legislation.
- Key message: Ongoing effort that requires a lot of time, but has a lot of potential.

II. Collaboration by Coalitions: Blackstone Valley (Pawtucket, Lincoln, Cumberland, N Smithfield, Woonsocket)

Have been working together for years because of physical proximity and like working together.

- Tobacco control
- Professional development and opportunities
- Regional approach at town hall meetings

Have been talking about formalizing regionalization between Pawtucket, Lincoln, Cumberland and N Smithfield and Woonsocket (Blackstone Valley or Greater Blackstone Valley)

- Sharing of resources: people, programmatic, physical, funding
    - More than just funding. They know that they can spread a buck.
        - If one creates a great program, it can be shared.

  Issues/questions that need to be explored for formal regionalization:
    - How do we structure it?
    - Which responsibilities are whose?
    - Need to develop Memorandums of Understanding (MOUs), Legal status, Financial considerations
    - Board structure
    - Pooling money from towns
    - Staffing structure. Strength and weaknesses of existing staff. Where are the offices? Hours, benefits.
    - 501c3 status of some coalitions.
    - Make sure that all the communities are represented.
    - Existing funding opportunities and new funding opportunities (have been working with RI Foundation for legal and financial resources)
- Have a desire to keep each community's identity (keep what works) but also collaborate/ integrate on many other issues.
- Next July is timeline

The following questions were posed at the meeting for future consideration (tabled):

- What are essential prevention elements?
- Is there a baseline for funding (example dollars allocated by size of community, data on degree of substance abuse by youth, scope of services provided etc.)?
- Are School Assistance Services (SAS) an essential element of prevention in RI?
- If SACs are essential, then perhaps a determination needs to be made about how to include that information in a statewide allocation assessment.
- How/are Marijuana (MJ) enforcement dollars going back into prevention?
- What is update on contributions from community compassion centers?
- Partnership for Success (PSF) Grant: Is there an option to allot some money for statewide media before it goes to the identified communities?
- What are effective regionalization models?

Next Steps

- Participants agreed to continue the presentations on collaboration efforts by prevention providers at subsequent meetings.
- Ask a few participants to continue to work on the proposed funding matrix.

- There are two volunteers to help with planning the June meeting: Jen Wall (E Providence), Laura Hosley (Jamestown). There will be a call for others to participate as well.
- Next meeting options: (will send out a Doodle to finalize date) June 18th or 25th: 1-3PM, August 13th or 20th. Doodle: http://doodle.com/unpc2kpwx9hn5c7w

Please Mark Your Calendars - Final Next Meeting Dates:

Wednesday, June 25th, 1-3pm at the community room at the South Providence Library (441 Prairie Ave, Providence, RI 02905)

Wednesday, August 13th, 1-3pm, conference room at Health Centric Advisors (235 Promenade Street, Providence, RI 02908)

Activity Description: Meeting with Rhode Island (RI) community prevention providers facilitated by JSI Research & Training Institute, Inc. (JSI) on behalf of the RI Department of Behavioral Healthcare, Department Disabilities and Hospitals (BHDDH).

Notes developed by: Beth Beatriz and Shannon Spurlock, JSI

Location: Community room at the South Providence Library (441 Prairie Ave, Providence, RI 02905)

Date: Wednesday, June 25, 2014, 1:00 P.M. – 2:30 P.M

Location: Warwick Public Library

Participants: See attendance sheet for list of 12 prevention providers, Charles Williams, Elizabeth Kretchman and Anna Meehan from (BHDDH) and Beth Beatriz (note taker) and Ann Marie Rakovic (facilitator) from JSI.

Background: At the request of the BHDDH, JSI was asked to facilitate a meeting with community substance abuse providers with the following objective:

> To facilitate the opportunity for prevention providers to share their knowledge and experience with successful collaboration efforts

An agenda was developed by BHDDH, JSI and provider volunteers and shared with participants.

Ground rules: Raise hand, one person speaking at a time, be aware of your "air time", and table issues to the "parking lot" that are important but should be discussed later.

Planning Call: Participants in the planning call emphasized that the collaboration presentations by fellow providers were beneficial and articulated a desire for those presentations to continue. Participants also described interest in having presentations from other states to outline different types of prevention systems, especially New Hampshire's regionalized model.

Review of the Minutes: Approved May 7th meeting minutes.

Meeting: Participants were invited to introduce themselves and share what they would like to address in these provider meetings. The purpose of the meeting refocused from regionalization to discussing broader prevention services and structure options.

The meeting began by reviewing the agenda, which includes presentations from local communities who have successful collaborative initiatives.

BHDDH reviewed the goals for prevention from the strategic plan and emphasized BHDDH continued to support prevention.

- The goals of the BHDDH prevention strategic plan were distributed.
    - The strategic plan will be updated in 2015 and community and provider input is wanted and needed.
    - Funding cuts and other capacity issues may need to be considered for the 2015 strategic plan.
- The role of the Prevention Advisory Committee (PAC) was reviewed, highlighting the development of a formal voice for prevention at the Governor's Council.
- A Workforce Development plan for prevention has been drafted and will be shared with providers once finalized.

The issue of legislative budget changes to prevention funding became the primary issue of concern. The focus of meeting transformed, with the permission of the group and community presenters, into a discussion about changes in how prevention is funded in RI. Main issues of discussion include:

- General Assembly voted to move RISAPA funds entirely under federal funds (Block Grant).
- The shift in funding streams was not a recommendation from BHDDH.
- The proposed act to increase RISAPA funds never left committee.
- Many BHDDH programs that used to be funded under State funds were moved to federal funds (more than just RISAPA).
- There has been a precedent for this happening by the RI General Assembly. HEALTH experienced/experiences similar situations.
- July 1, 2014 (beginning of the State fiscal year) is the effective date for the shift.
- There are funds to cover (at the very least) the next 4 to 6 weeks after the shift so continue to bill for hours worked.
- RISAPA legislation does not specifically include or exclude revenue streams.
- BHDDH is process of reviewing Block Grant funding and making decisions regarding how funds will be allocated based on the revised state budget.

BHDDH reviewed the context and history of how prevention has been funded historically.

- RI uses more than almost other states for prevention in the Block Grant (38% versus 20% requirement). Included in this 38%: RISAPA, Student Assistance, URI, MOD, and RIPRC.

- Rhode Island has not and may not this year meet 'maintenance of efforts funds' level required by the grant (similar to a 'match' requirement).

The group highlighted some questions and concerns:

- Is BHDDH funding too many initiatives to be effective (i.e. RISAPA, Student Assistance, URI, MOD, RIPRC)? Why are they all funded?
    - The increase in the percentage of Block Grant allocation to prevention was implemented to offset budget cuts to student assistance and RISAPA.
    - To be in compliance with federal guidelines: we must have all 6 strategies covered. To only fund RISAS and coalitions, both would need to change their scope of work and capacity significantly in order to meet all 6 strategies. RIPRC and URI are part of compliance regulations and were directly recommended by the federal funder.
- Prevention's relationship with the State Legislature has fundamentally changed now that they aren't funded by the General Assembly.
    - For the most part the prevention providers are funded through a municipal entity so that relationship still exists with the legislature.
- Should these community conversations about the prevention system be postponed until funding decisions have been made at BHDDH?
- What happens to federal dollars that require a 100% match? House of cards.
- Is there legislative recourse?
    - When legislature prepares the 2016 budget, changes could be made to the 2015 budget.
    - DFC grantees using the RISAPA funds as part of the required match, could advocate for more funds from part of the town's/school board's budget.
    - Representatives maybe respond if municipals reach out on behalf of the providers and indicated that GA made previously matched dollars unmatchable with no notice.
- The MOD initiative is first in the country and is a model for other states.

The group documents some specific steps for follow up:

- Document unintended consequences of transfer to exclusively Block Grant funds (e.g. DFC matching funds, etc.).
- Reach out to SAMHSA to officially weigh in as the previously approved budgetary plan will have to change.
- Communities where the local match is at-risk may consider letting your federal agent know what is going on.
- ***Taking one type of action may not be enough***. Consider engaging local officials, document repercussions, engage media and continue discussions about the future of the prevention system in Rhode Island.

Follow-up items:

- Continue presentations on collaboration efforts by prevention providers at subsequent meetings.
- Volunteers to continue work on the proposed funding matrix.
- For August Meeting: Betsy reached out to Valerie in NH about presenting. There was a suggestion of a panel of NE state prevention system organizations. Not finalized yet, but discussions have begun.
- Top three priorities from last meeting:
  - Map current funding levels and services by coalitions across the state
  - Investigate best prevention service delivery models
  - [TIE] Review current and planned community collaborations
  - [TIE] Map BHDDH Strategic Plan for Substance Abuse and Prevention onto current services
- Collaboration Presentation(s): (#1) Portsmouth/Tiverton/Newport/ Jamestown/Middletown and (#2) East Providence/Barrington
- Large group discussion: observations of lessons learned and best practices on the road to effective collaboration

Close:

- Review of follow-up items and volunteers needed for upcoming **August 13th** planning session (next full group meeting is 8/13/14 Health Centric Advisors, 235 Promenade Street, Providence, RI, 02908).
- HOW DO WE GO FORWARD?
  - Have a planning call to discuss future discussions. Set for July 21st at 11am.
  - Set date for next quarter meeting

III. Training Agenda and Evaluation Results

LGBQT Evaluation Summary
January 30. 2014

Scale: 1.) Strongly Agree, 2.) Agree, 3.) Disagree, 4.) Strongly Disagree

The survey results from the presentation displayed that the participants genuinely enjoyed and learned a lot during it. All participants either "agreed" or "strongly agreed" that:

- The objectives were clear.
- The presenter(s) were knowledgeable.
- The materials enhanced overall understanding.
- The format, style, and time were all appropriate.
- The presentation was interesting & applicable to their work setting.
- Felt welcome to participate & would recommend this training to a colleague.

The audience also acknowledged that additional training and information would also be helpful. In conclusion, the presentation was successful in engaging its participants—causing them to think critically, ask questions, and increase his or her desire to learn more about the topic.

Thirty-one (31) participants completed the evaluation feedback for the "LGBTQ! Positive Training" immediately after the completion of the training. Participants were asked to rate how effective and appropriate different elements of the training were. On a scale of 1-4, with 1 correlating to "strongly agree" and 4 correlating to "strongly disagree", overall participants "strongly agreed" that the objectives were clear (average score= 1.16); the presenters were knowledgeable (average score= 1.06); the materials provided in the training enhanced understanding (average score=1.19); the format and style of the training were appropriate (average score=1.17); the presentation was interesting (average score=1.15); they felt welcome to participate (average score=1.20); the length of program was appropriate (average score=1.32); the material learned was applicable to their work (average score=1.16); they would recommend the training to a colleague (average score=1.18); and that they would be interested in additional training on the subject matter (average score=1. 42). Participant feedback was overall very positive with particular appreciation for the relevance/importance of subject matter, extensive knowledge of the presenters and the variety and type of activities that were present throughout the training

IC&RC Prevention Specialist Certification Test Preparation Training Evaluation

On Tuesday, May 27th, 14 Rhode Island Prevention Providers participated in certification preparation training from 9am to 1pm at the Warwick Public Library. Of those, 13 participants completed a feedback evaluation of the training. The results of those evaluations are chronicled in this document.

Results summary:

I. Objectives															**3.77**
A Working Definition of Prevention	4	3	4	4	4	4	4	3	3	4	4	4	4		3.77
Prevention Specialist Certification Domains	4	4	4	4	4	4	3	3	3	4	4	4	4		3.77
Content Covered in the Prevention Certification Test	4	3	4	4	4	4	4	3	3	4	4	4	4		3.77
II. Program Content															**3.83**
Topics covered in a logical manner	4	4	4	4	4	4	4	3	3	4	4	4	4		3.85
Appropriate amount of time allowed to discuss each topic	4	4	4	4	4	4	4	3	3	4	4	3	4		3.77
Session was informative	4	4	4	4	4	4	4	3	3	4	4	4	4		3.85
Session was thought-provoking	4	4	4	4	4	4	4	3	3	4	4	4	4		3.85
III. Site and Materials															**3.66**
Training room was adequate	4	4	3	4	4	3	4	3	3	4	4	4	4		3.69
Handouts were sufficient	4	4	3	4	4	4	4	3	2	4	4	4	4		3.69
Visual aids (slides) were adequate	4	4	3	4	4	3	4	3	2	4	4	4	4		3.62
IV. Presenters															**3.87**

Session presented professionally	4	4	4	4	4	4	4	3	4	4	4	4	4		3.92
How satisfied were you with the speaker/presenter?	4	4	4	4	4	4	4	3	3	4	4	4	4		3.85
Session was well organized	4	4	4	4	4	4	4	3	3	4	4	4	4		3.85

Overall, the participants scored all elements of the presentation highly, with all participants scoring primarily 4's, the most positive score. All elements of the training evaluations had mean scores of over 3.5 (on a scale of 1 through 4), with the range between (3.62, 3.92).

RI Prevention Resource Center

IC & RC Prevention Specialist Certification Test Preparation Training

May 27, 2014
9:00AM-1:00PM
Warwick Public Library, 600 Sandy Lane, Warwick, RI, 02889
Trainer: Sandra Del Sesto

Agenda

Training Objectives:

1. Participants will have a working definition of Prevention based on the Institute of Medicine (IOM) and Substance and Substance Abuse and Mental Health Service Administration (SAMHSA) definitions.

2. Participants will be able to identify and have a working definition of all IC&RC Prevention Specialist Certification Domains: Planning & Evaluation, Prevention Education & Service Delivery, Communication, Community Organization, Public Policy & Environmental Change and Professional Growth & Responsibility.

3. Participants will review content covered by the PSC test including but not limited to facilitation, evaluation, drugs and the brain and testing strategies

9:00-10:00:

Welcome
Review Objectives
Review IC&RC and the Benefits of Certification

10:00-11:00:

Prevention Specialist Requirements
Review Exam
Scoring Criterion

11:00-12:00:

Break
- Institute of Medicine's Definition of Prevention
- Continuum of Care
- Review IC&RC Prevention Domains
- **12:00-1:00:**

  - Reference list

- Test taking strategies
- Practice!
- Q & A
- Close

An Introduction to Conducting and Facilitating Focus Groups
June 10, 2014

Agenda

INTRODUCTIONS, TRAINING OBJECTIVES, BACKGROUND ON FOCUS GROUPS

9:00 – 9:20

- Examples of qualitative methods
- Why conduct focus groups
- Benefits and drawbacks

FOCUS GROUP OVERVIEW

9:20 – 9:35

- Preparing for focus groups
- Recruiting participants
- Consent forms

FACILITATOR AND NOTETAKER

9:35 – 9:55

- Role of a facilitator
- Traits of a strong facilitator
- Common facilitator pitfalls
- Role of the note taker

BREAK

9:55 – 10:05

DEVELOPING A FOCUS GROUP GUIDE

10:05 – 10:20

- Components of a focus group guide
- How to use the guide
- Types of questions to include

EXERCISE

10:20– 10:45

- Developing focus group guide questions

BREAK

10:45 – 10:55

LISTENING AND FACILITATION SKILLS

10:55 – 11:10

EXERCISE
11:10– 11:25
Mock Focus Group

DATA COLLECTION AND ANALYSIS
11:25 – 11:50
Collecting & organizing qualitative data
Analyzing qualitative data
Dissemination of data findings

CLOSING
11:50– 12:00

Evaluation Results

Please find below the evaluation results for each question using the following rating scale:

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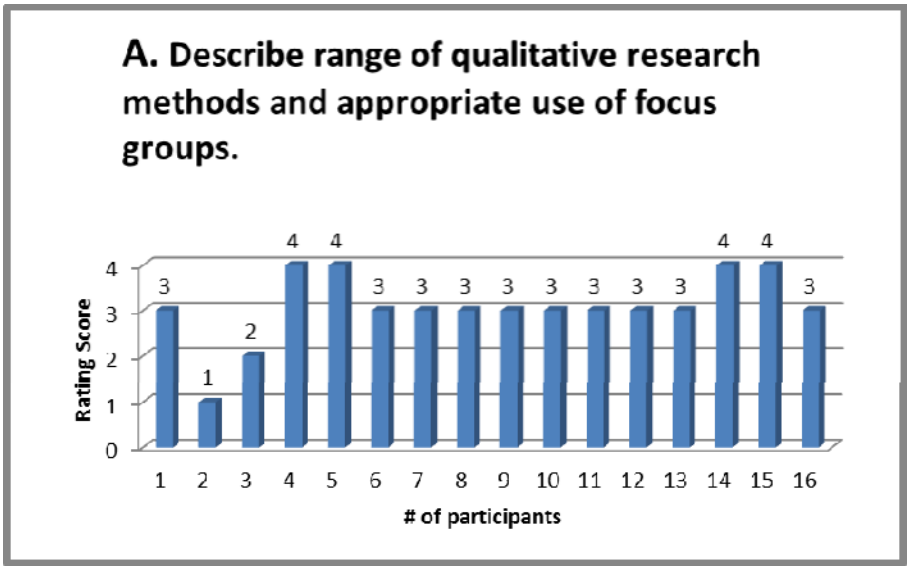
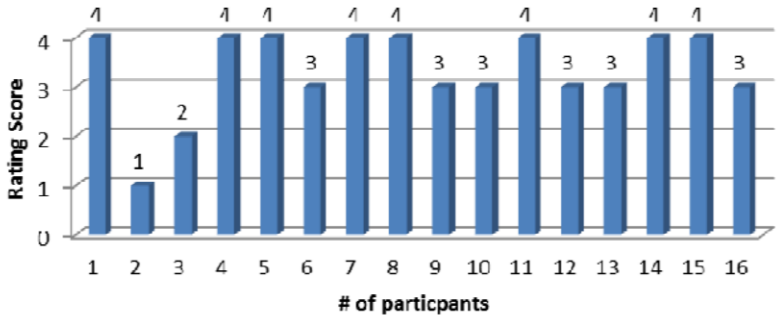
1 To a very low extent 2 To a low extent 3 To a moderate extent 4 To a high extent

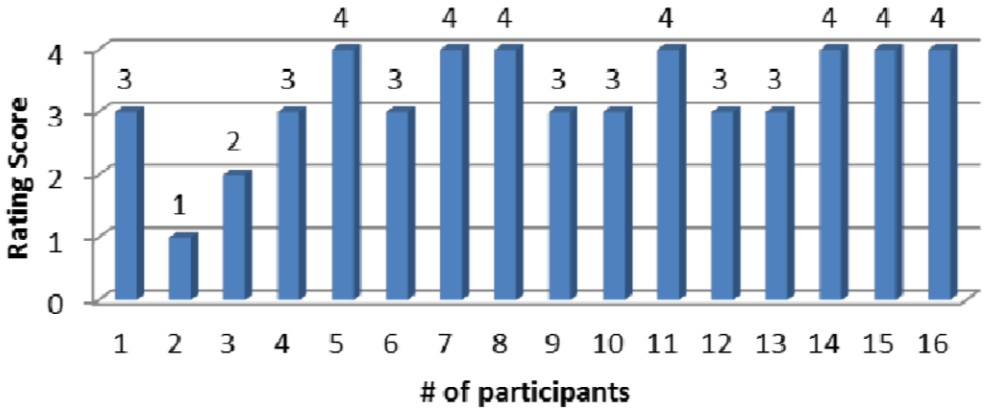
I. Objectives:



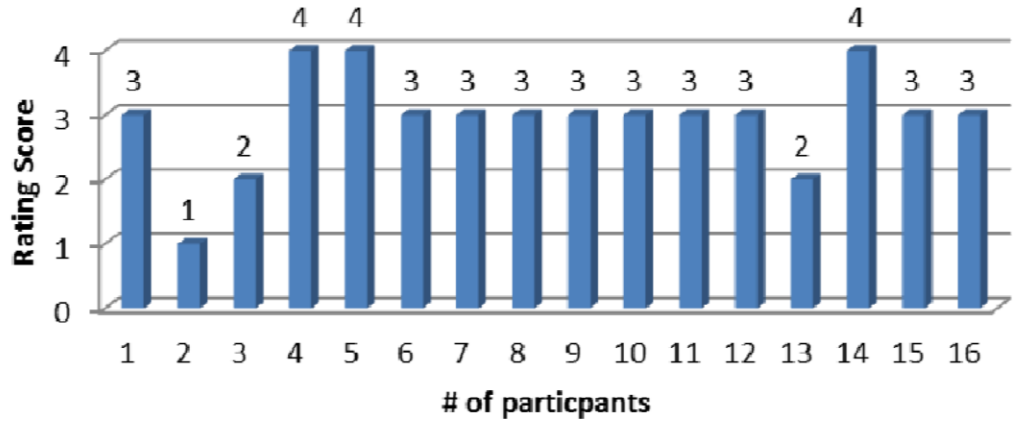
B. Describe effective focus group preparation, including recruitment strategies and guide.



C. Demonstrate and apply focus group facilitation skills.

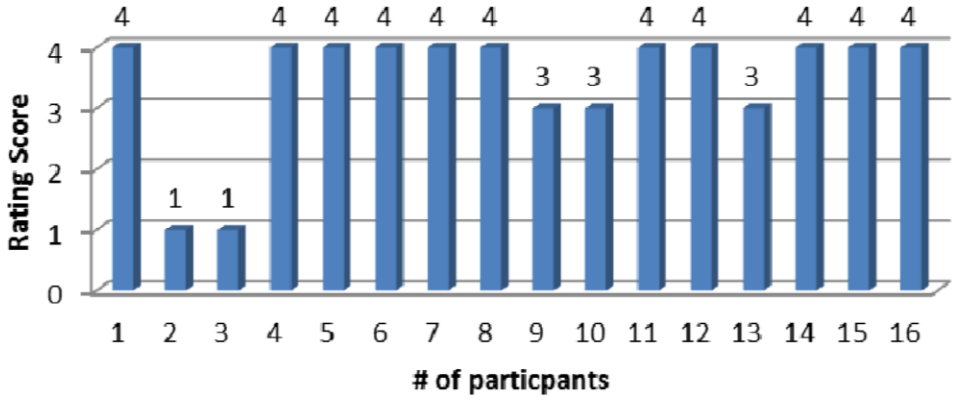


D. Analyze and present focus group findings effectively.

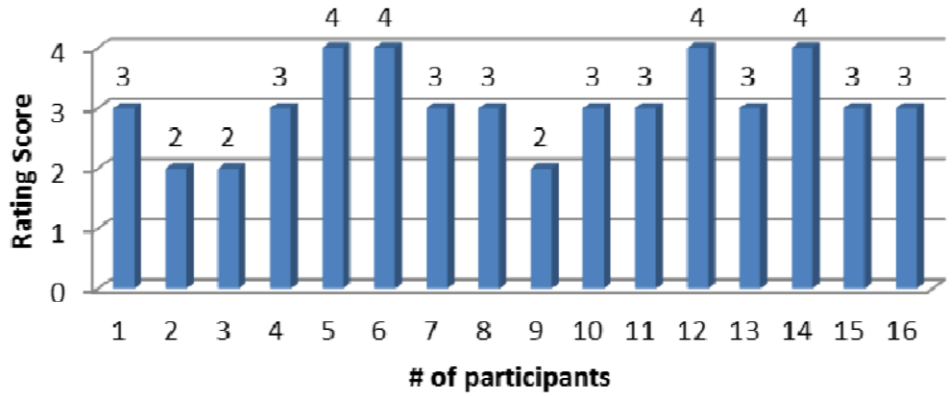


II. Program Content

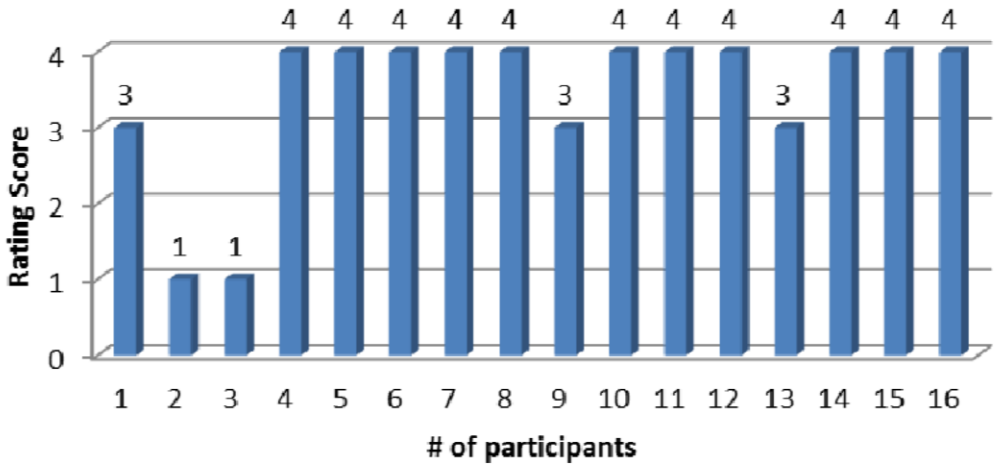
A. Topics were presented in a logical manner.

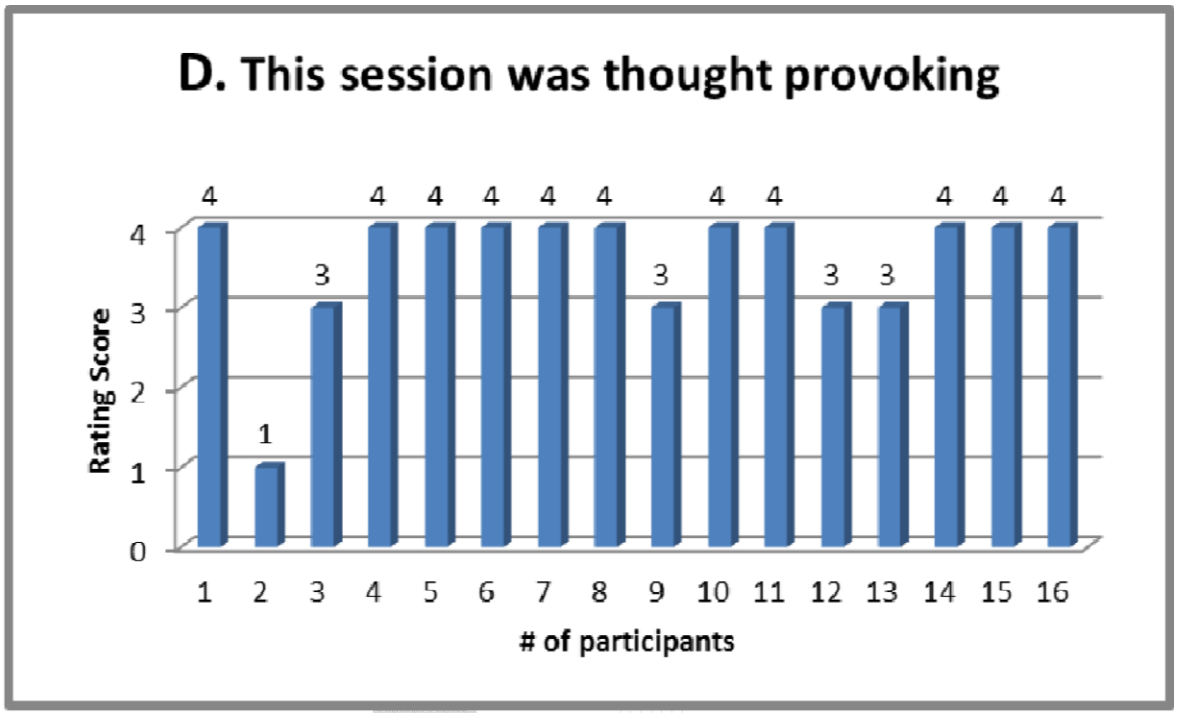


B. Enough time was allowed to discuss each topic.



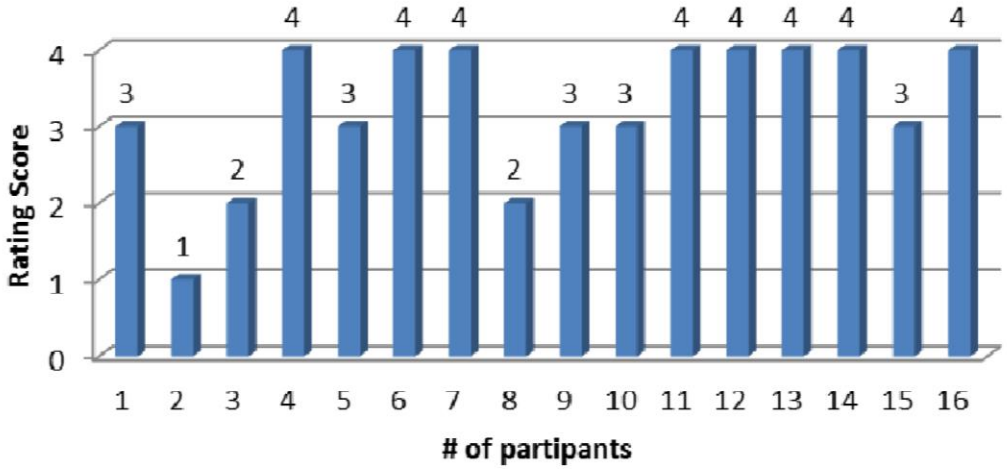
C. This session was informative.



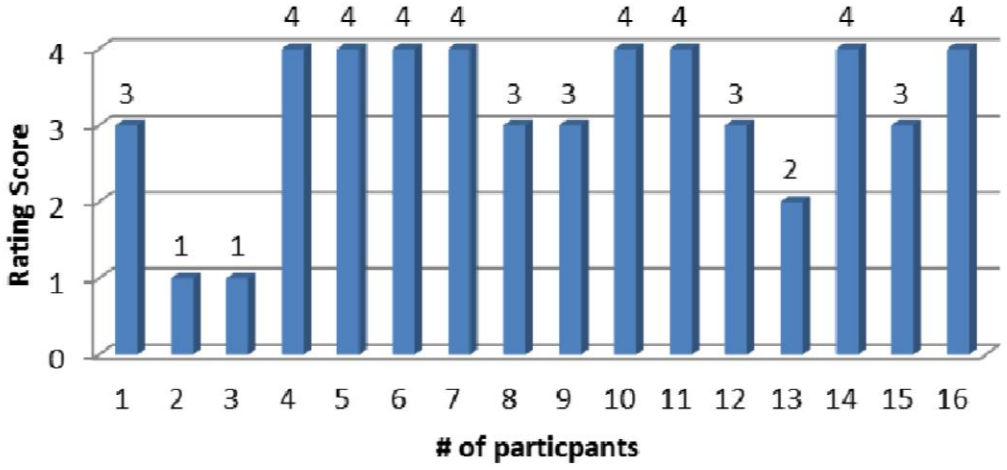


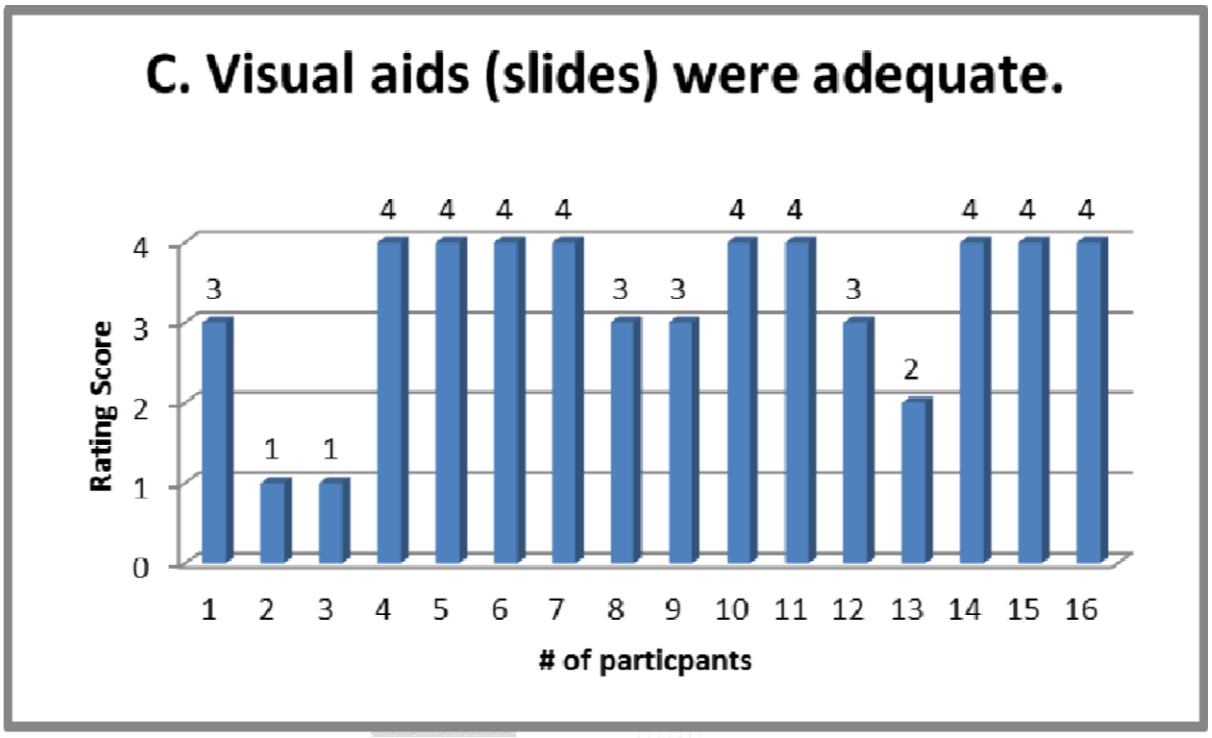
III. Site and Materials

A. Training room(s) was adequate.



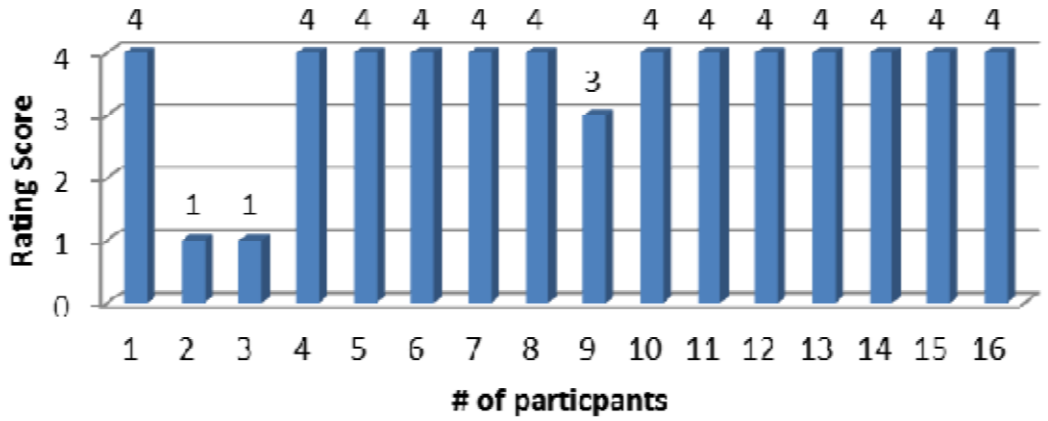
B. Handouts were sufficient.



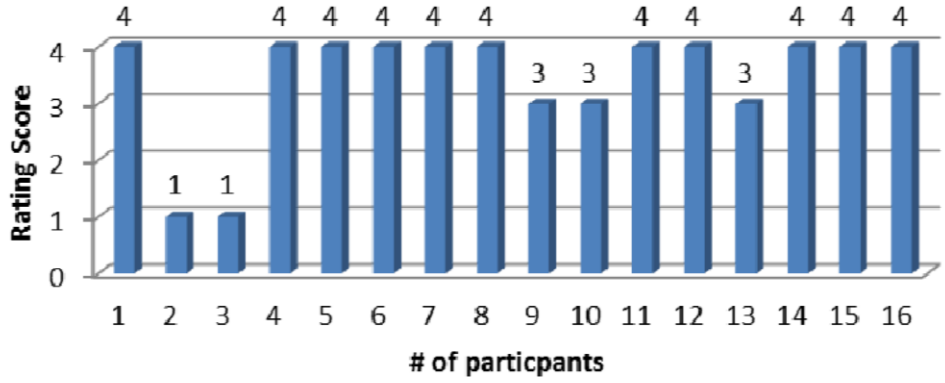


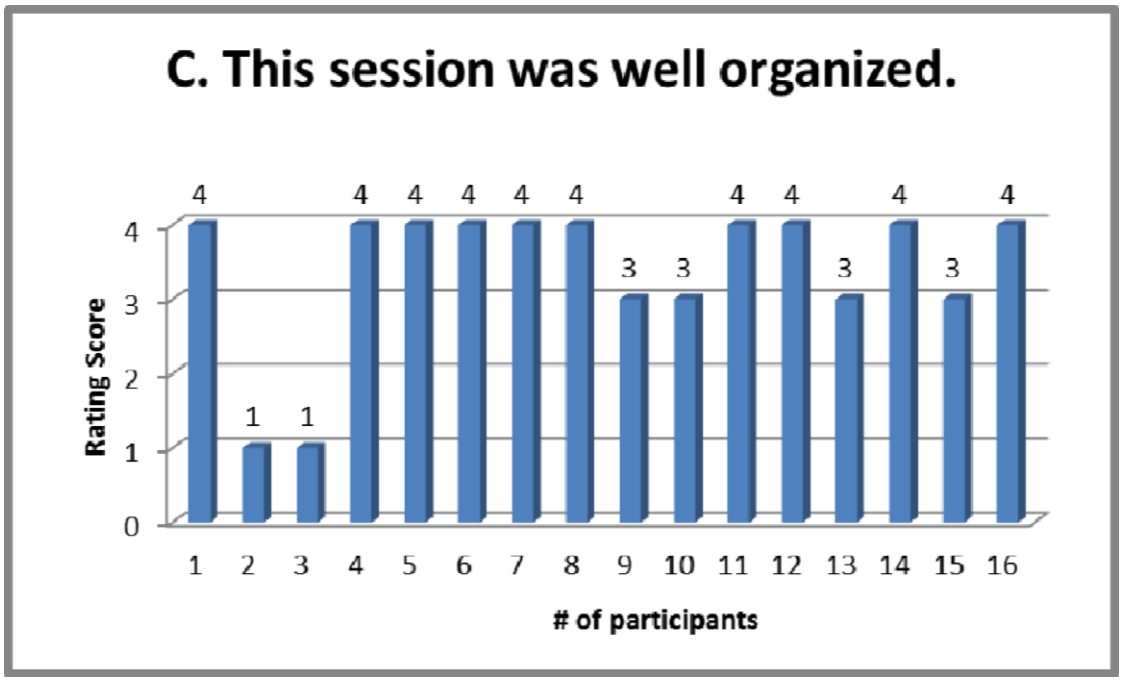
IV. Presenters

A. This session was presented professionally.



B. Overall, how satisfied were you with the speakers/presenters?





V. *General Comments*

I would like the next evaluation training to include information on:

- I will be able to answer this question better once I have more experience in conducting a focus group.
- Program funding and program writing.
- How to determine the appropriate population for the focus group.
- Certification.

Other Comments:

- Use a substance abuse example, Steve. Although info regarding HIV focus groups is transferable, a substance specific example would have been more meaningful.
- Some of the content was a little rushed. Content was great though and presenters was very informative.
- Great presentation: as someone with no prior experience with focus groups, I definitely learned a lot.
- Rather start on time and cover all agenda items than out of an activity. Perhaps more time for small group activities.

- Perhaps more examples used to illustrate points

Using Data to Improve Programs and Enhance Strategic Planning

June 10, 2014

Agenda

I. What is Data?
Basic understanding of data

II. Data, Information and Knowledge:
How all three are inter-related and are important to programming and planning

III. Where and How:
Sources of Data (brainstorm exercise)
Where does data come from? Best methods for identifying and collecting it.

IV. What Does it Mean?
How to inform and target programming
Survey Data Analysis and Presentation

Break

V. Data for Planning - The Needs Assessment:
Main Components of a Needs Assessment -
Why quantitative data should be used to inform what you collect for qualitative data (i.e. key informant and focus groups, etc.)
Other data sources to consider using (trends and local issues)

VI. Now what? Aligning Data Collection to Your Theory of Change & Logic Model Construction
Use of data to justify a theory of change and create a logic model.
Discuss National Outcome Measurements and why they are important.
How data can be collected to help inform progress being made on the logic Model.

VII. Using the Data to Inform Strategic and Action Plans:
A discussion of how to use data to inform strategic planning process.
Comparison to local, state and national data sources.
Focusing on local conditions and special needs.

VIII. Questions and discussion
Evaluation

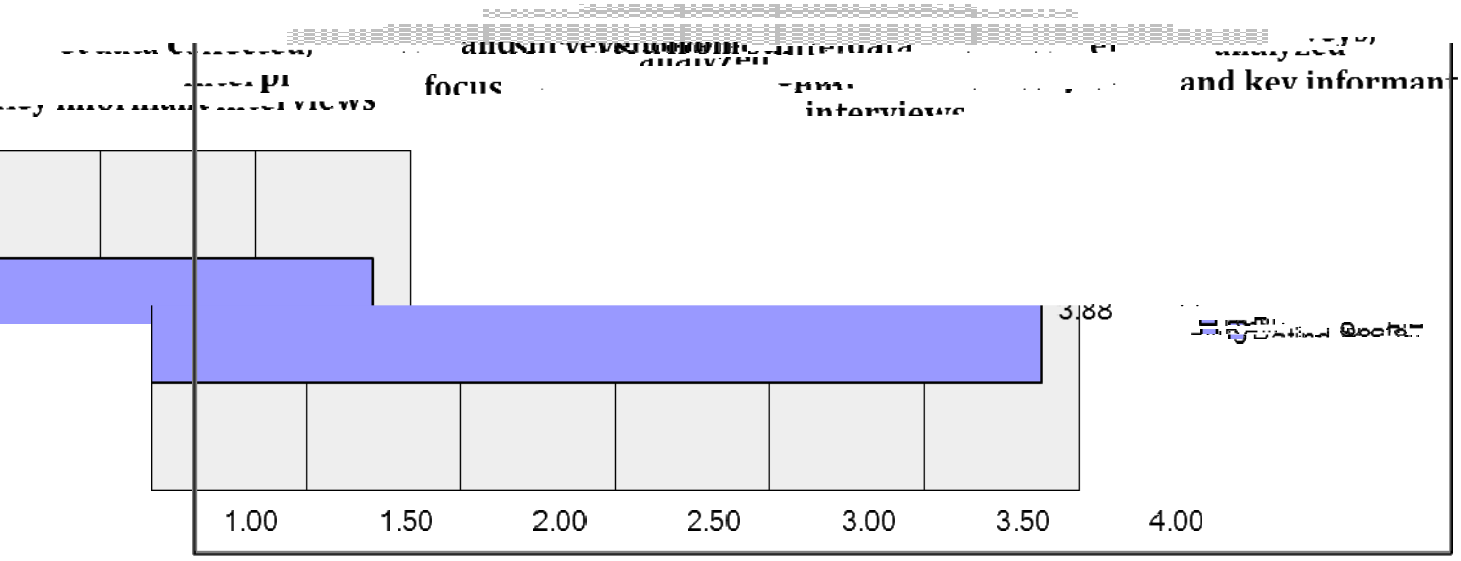
Below, please find the evaluation results from the RIPRC training held in Buttonwoods Community Center, located in Warwick, RI on June 24th, 2014. The following rating scale was used to analyze the data.

1 To a very low extent 2 To a low extent 3 To a moderate extent 4 To a high extent

I. Objectives

Q1.

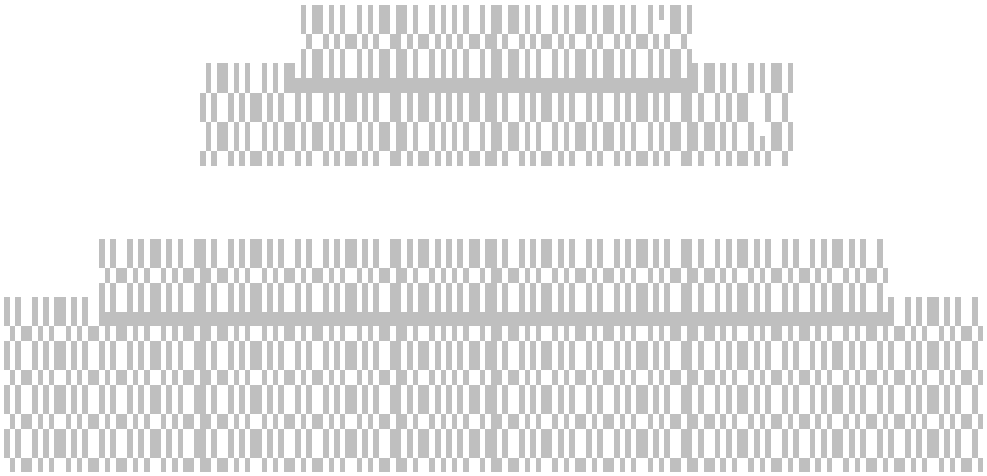
Interpret data collected, analyzed and reported from surveys, focus groups and key informant interviews						
Answer Options:	To a low extent			To a high extent	Rating Average	Response Count
	0	0	2	14	3.88	16
answered question						16
skipped question						0



Q2.

Be able to align data findings to your logic model

Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	0	1	6	9	3.50	16
answered question						16
skipped question						0

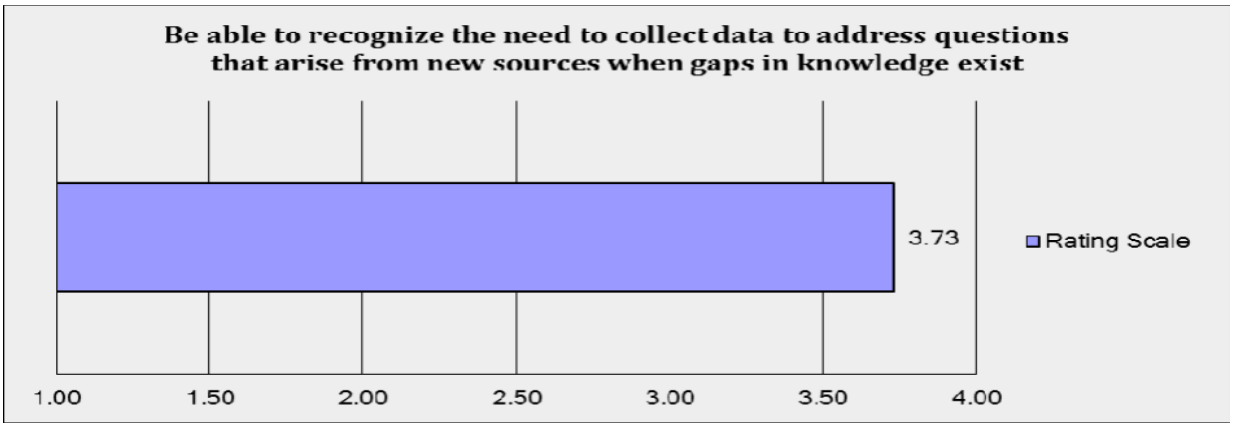


Q3.

Be able to recognize the need to collect data to address questions that arise from new sources when gaps in knowledge exist						
Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	0	0	4	11	3.73	15
answered question						15
skipped question						1

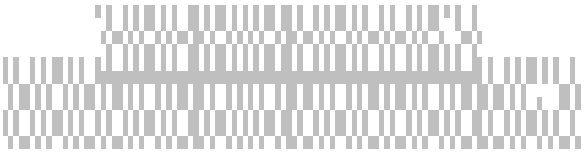
Q4.

Know how to recognize what data is useful and informative to their work, and which is not						
Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	0	0	5	11	3.69	16
answered question						16
skipped question						0



Q5.

Be able to identify emerging trends using needs assessments and data reports						
Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	0	0	4	12	3.75	16
answered question						16
skipped question						0

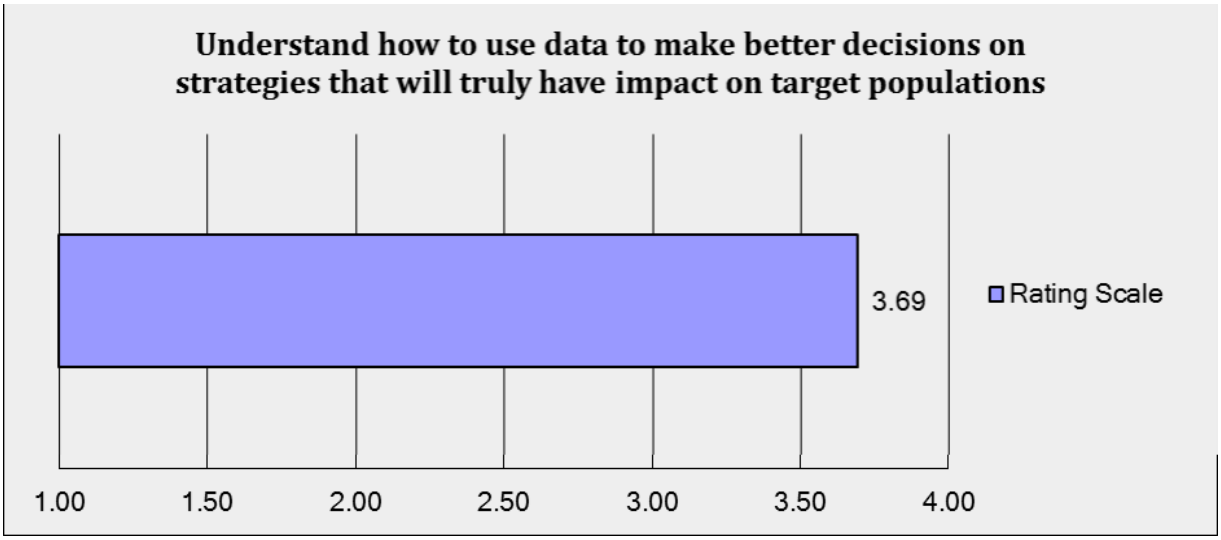


Q6.

Understand how to use data to make better decisions on strategies that will truly have impact on target populations						
Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	0	0	5	11	3.69	16
answered question						16
skipped question						0

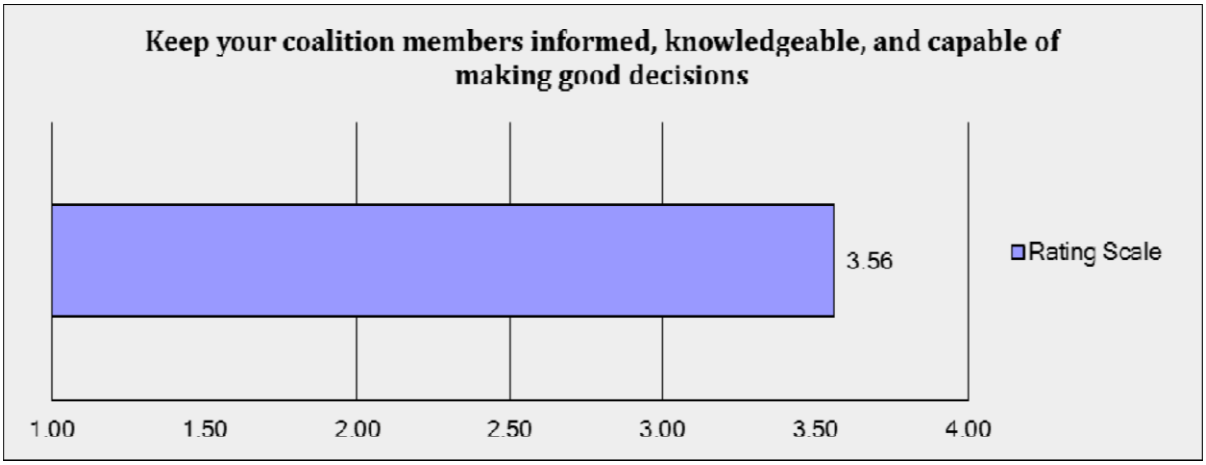
Q7.

Make better decisions that allow more effective use of limited resources (staff and volunteer time and money)						
Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	0	0	5	11	3.69	16
answered question						16
skipped question						0



Q8.

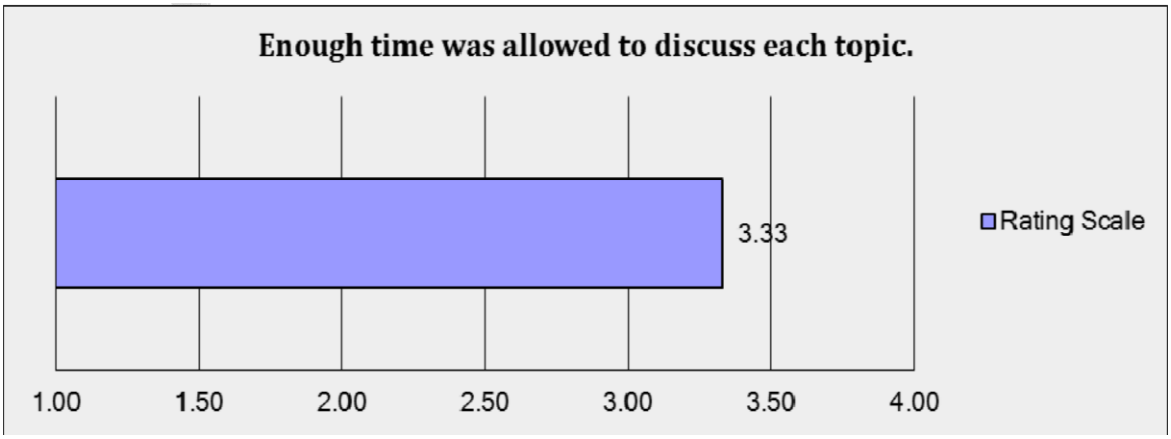
Keep your coalition members informed, knowledgeable, and capable of making good decisions						
Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	0	0	7	9	3.56	16
answered question						16
skipped question						0



II. Program Content

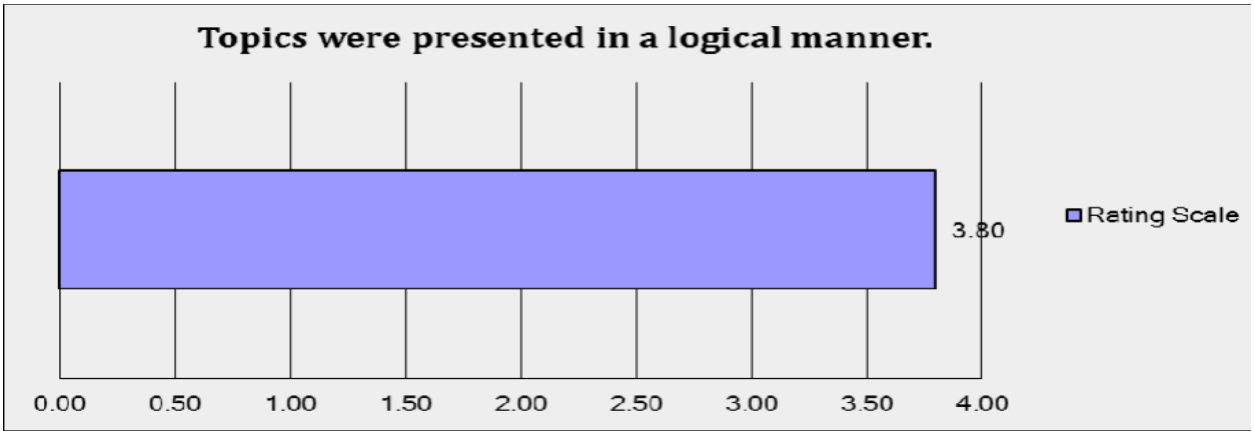
Q9.

Topics were presented in a logical manner.						
Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	0	0	3	12	3.80	15
answered question						15
skipped question						1



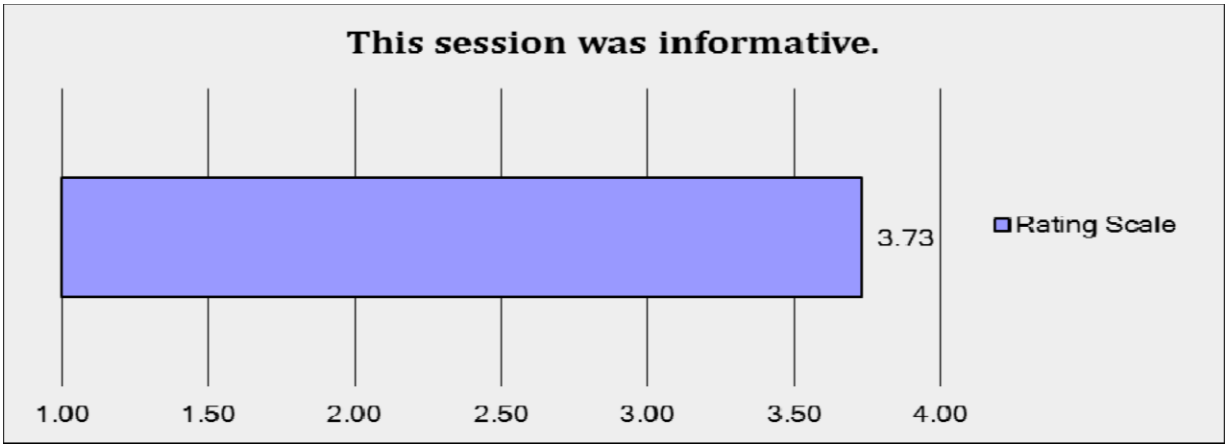
Q10.

Enough time was allowed to discuss each topic.						
Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	0	1	8	6	3.33	15
answered question						15
skipped question						1



Q11.

This session was informative.						
Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	0	0	4	11	3.73	15
answered question						15
skipped question						1



Q12.

This session was thought provoking.						
Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	0	0	6	9	3.60	15
answered question						15
skipped question						1

ating Scale

III. Site and Materials

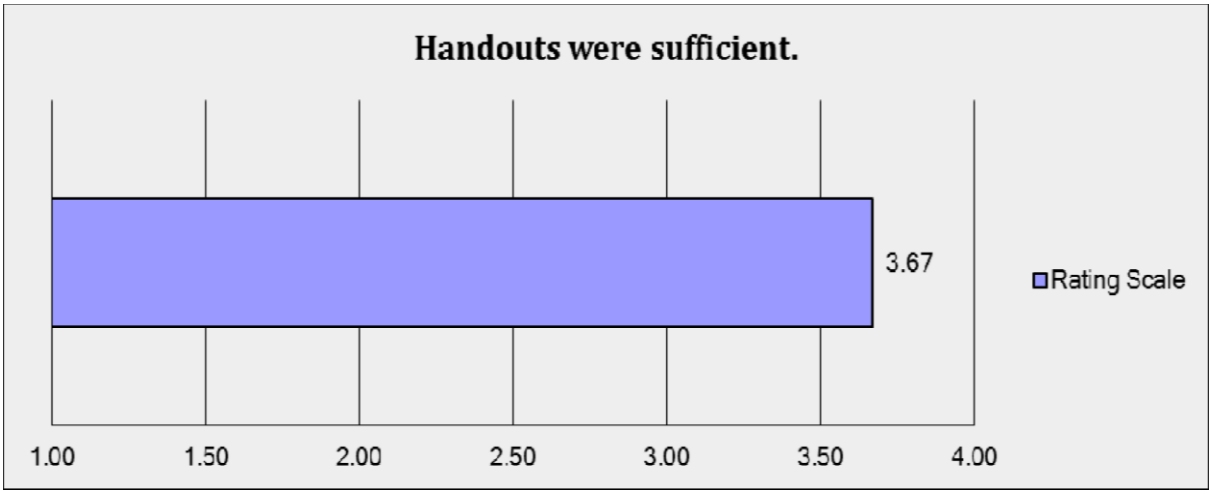
Q13.

Training room(s) was adequate.						
Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	3	4	4	4	2.60	15
answered question						15
skipped question						1

Rating Scale

Q14.

Handouts were sufficient.						
Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	0	1	3	11	3.67	15
answered question						15
skipped question						1



Q15.

Visual aids (slides) were adequate.						
Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	0	0	2	13	3.87	15
answered question						15
skipped question						1

ating Scale

IV. Presenters

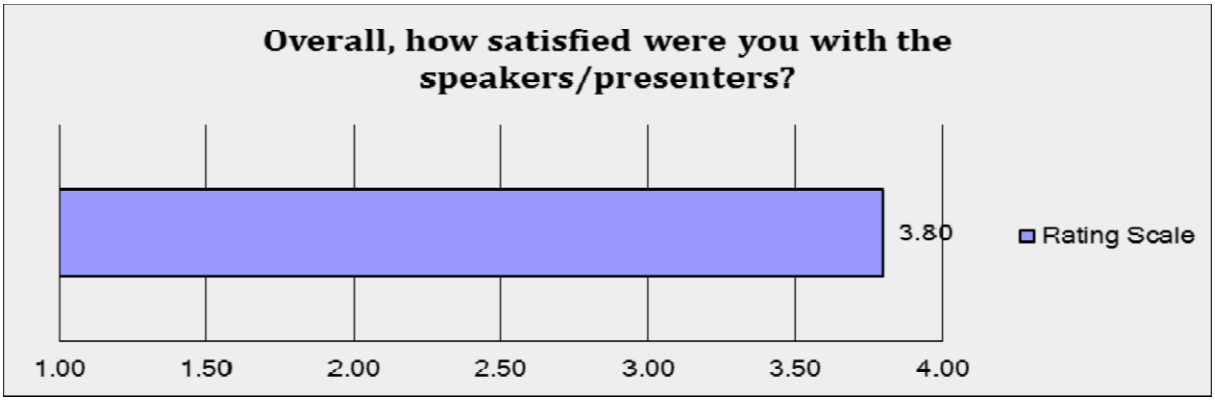
Q16.

This session was presented professionally.						
Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	0	0	1	14	3.93	15
answered question						15
skipped question						1

Rating Scale

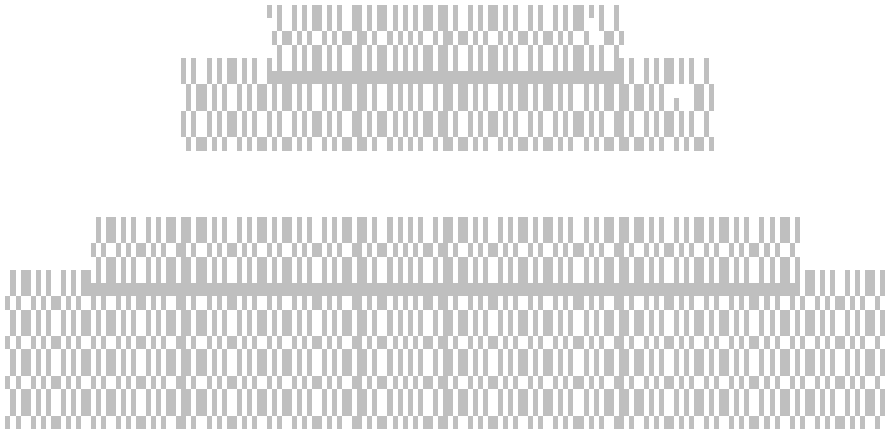
Q17.

Overall, how satisfied were you with the speakers/presenters?						
Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	0	0	3	12	3.80	15
answered question						15
skipped question						1



Q18.

This session was well organized.						
Answer Options	To a low extent			To a high extent	Rating Average	Response Count
	0	0	2	13	3.87	15
answered question						15
skipped question						1



V. General Comments:

Q19.

I would like the next evaluation training to include information on:	
Answer Options	**Response Count**
	1
answered question	**1**
skipped question	**15**

Response Text

- Logic models, How to!
- Youth Participation Aides
- Capacity Building for Coalition"

Q20.

Other Comments:	
Answer Options	**Response Count**
	6
answered question	**6**
skipped question	**10**

Response Text

- Great training - needed full day and moved quickly, held interest.
- Room was cold.
- Room too cold.
- The room was too cold.
- Room was too cold!
- Thanks!

In conclusion, this training was well received.

IV. Riprc.org Six Month Digital Analysis Report

RHODE ISLAND
prevention resource center

Riprc.org Digital Analysis
Six Month Report [September 2013-February 2014]

This report was prepared by JSI Research & Training Institute, Inc. (JSI) for the Rhode Island Prevention Resource Center (RIPRC) and submitted to the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH).

JSI Research & Training Institute, Inc.

I. Introduction

This report looks at riprc.org and other related online marketing effort's visibility, and visitor activity and behavior from September 2013 to the end of February 2014. We used Google Analytics' tracking system, Campaign Monitor, Facebook and YouTube to collect the data.
The data presented in this report can be compared to our previous digital analysis report run in August 2013 to understand changes in and/or consistency of riprc.org's user activities.
Currently, optimizations to the site based on recommendations from the previous 6 month report are under development. The next report [September 2014] will be looking at the impact of the newly implemented features.

Understanding Google Analytics' Basic Terms

Visits: A visit is registered when Google Analytics tracking code is activated on a visitor's entrance to the site. Everything the visitors do within that visit on the site is tracked until they leave or the session expires (after 30 min of inactivity). The **Source** of a visit is the specific place that sent the visit to your site. Possible sources include search engine (eg. "Google"), referring site (e.g. "facebook.com"), and "direct" (visitors typed the URL directly into their browser, or had bookmarked the site).

New and Returning Visits: Through the use of cookies, Google Analytics registers if a visitor has been to a site on that browser before and if so, tracks it as a Returning Visit. If not, the visitor is tracked as a New Visit. A repeat visitor using a different browser or computer for another visit will be tracked as a New Visit, as cookies are held within individual browsers.

Visitors: The number of visitors will always be lower than the number of visits to a site because some visitors will visit the site more than once.. A visit is time on the site whereas a visitor is a group of visits made on one computer, through one browser that has stored the cookies to track the visits to this one visitor.

Bounce Rate: A 'Bounce' is a visit to a site in which the visitor only looked at one page. The 'Bounce Rate' is the percentage of visits that viewed only one page before leaving the site.

A low Bounce Rate indicates that visitors are engaging with your site. Depending on the type of site, a typical Bounce Rate could be between 30% and 50%. Sites such as blogs will often see a higher Bounce Rate as many people only come to the site to read a post they have heard about; when they enter the site arriving on that post and exit after reading it their visit counts as a Bounce.

Pageviews: A pageview is a view of a page (taking into consideration that when you navigate on a site, you may arrive on the same page several times during a session).

Unique pageviews are the number of visitors to a page, rather than the number of visits to that page.

Pages per Visit: This is how many pages a visitor views in one visit, which provides information on the depth of visit on the site, i.e. how much visitors "look around".

III. Riprc.org Activity and Reach

1. Overview

Riprc.org received a total of 3,715 visits between September 2013 and February 2014, coming from 2,637 unique visitors (compared to 1,446 visits and 726 unique visitors during the previous 6 month period: March-August 2013)

In total, the site had 10,541 pageviews (compared to 7,116 in previous 6 month period), 6,538 unique pageviews (vs. 4,216)

Average number of pages visited per visit was: 2.84 (vs. 4.92)

Average time on site per visit was 3 minutes, 31 seconds (vs. 5 minutes, 51 seconds)

Bounce rate was 37.50 % (vs. 46%)

2,617 visits (vs. 1,356 visits) were computer-based, 1,098 visits (vs. 90 visits) came from a mobile device (iphone: 564 vs. 42, ipad: 212 vs. 25)

2. Monthly Activity

	Sept*	Oct	Nov*	Dec*	Jan**	Feb
Visits	258	232	269	2,192	408	356
Unique visitors	134	137	165	1,855	254	261
Pageviews	1,400	971	1,428	4,125	1,560	1,057
Pages per visit	5.43	4.19	5.31	1.88	3.82	2.97
Avg. time on site (mins)	7:53	4:35	7:02	2:02	5:27	3:30

**Enews sent that month: 9/30, 11/13 and 1/14 & 1/28 respectively*

**On December 9th, 2013, RIPRC team sent an email announcing that the 2013 RI Community Profiles were released and posted on riprc.org, the site received a massive visibility increase in the three days following the email.*

3. **Source of riprc.org Traffic**

Direct traffic: 22 % of visitors entered in the website address directly

Search engines: 26 % of the traffic to the RIPRC website is driven by search engines. The top search terms or keywords included: "rhode island prevention resource center," "bhddh," "riprc.org," "elizabeth kretchman, " "prevention resource."

Referring sites: 52 % of users found riprc.org through a link on another website or via another platform (bristol-warren.patch.com, coventry.patch.com, tiverton.patch.com, portsmouth.patch.com, newport.patch.com, RIPRC enews, RIPRC e-mail, JSI enews, JSI website, Facebook, etc.)

Note: many of the December 2013 visits came from a referring news-related website.

Social media: 34 visits came from Facebook, 2 from LinkedIn

4. **Ranking of Pages by Number of Pageviews**

1.	RI Community Profiles	**3,109**
2.	Rhode Island Prevention Resource Center (RIPRC) Homepage	**1,767**
3.	Prevention Basics	**475**
4.	Calendar	**365**
5.	Substance Abuse Prevention Providers	**354**
6.	BHDDH	**247**
7.	Info Center/Data Resources	**218**
8.	Provider Profiles	**209**
9.	Info Center	**192**
10.	Meet our Team	**176**
11.	YPI Video Profile	**161**
12.	Contact Us	**160**
13.	State Publications	**154**
14.	Recorded Webinars	**151**
15.	Info Center/Tools	**146**

5. **Top External Sites Accessed and Top Downloaded Documents from riprc.org**

External links accessed Total: 389	Documents downloaded Total: 2,215
RIPRC blog (note: provider profiles are posted as blog posts)	Bristol Community Profile
Youtube (YPI video is posted on youtube)	Barrington Community Profile
RIPRC Facebook page	Tiverton Community Profile
thebayteam.org	Warwick Community Profile
bhddh.ri.gov	Portsmouth Community Profile

IV. Related Online Marketing

1. **RIPRC Update (enews)**

Number of Recipients: 244 (as of February 2014)

Average Open Rate: 47 % – exceeding the health and health care campaign average open rate of 30%

Clicked a link: 35% out of recipients that opened the enews

2. **YPI Video**

The YPI video, posted on the newly created RIPRC YouTube channel received 310 unique views since it was posted in January 2014.

3. **Facebook**

Over the last 6 months, we have created 164 Posts, had 87 Likes and 5 Shares of a post. We currently have 43 followers receiving alerts when we post/share new content or engage in other activities.

IV. Closing Summary

We continue to make strides in increasing visibility of riprc.org and engaging visitors through related online marketing tools.

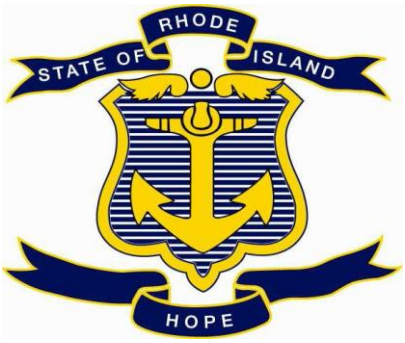
In the 6 month period from September 2013-February 2014, we more than doubled visitors to the site and saw a corresponding increase in pageviews on riprc.org compared to the previous digital analysis report (August 2013).

Similarly we grew our RIPRC Update (enews) and Facebook audiences and continue to have a consistent level of engagement with the content (open rates, clicks, likes, shares, etc.) as in the previous period.

The next analysis will look specifically at optimizations currently being implemented and their impact on user activity, this will be submitted in September 2014.

V. Workforce Development Draft Plan

State of Rhode Island



Substance Abuse Prevention Workforce Development Plan

2014-2015

DRAFT

Draft version submitted: 06/04/2014

RHODE ISLAND SUBSTANCE ABUSE PREVENTION: WORKFORCE DEVELOPMENT

One of the greatest challenges to the substance abuse prevention field in Rhode Island, as well as nationally, is the recruitment of new employees, and the retention of current ones, as the workforce ages into retirement or changes careers. BHDDH is dedicated to the recruitment, retention, education, and training of substance abuse treatment and prevention professionals and to improving the quality of our workforce. BHDDH is currently working with the New England Addiction Technology Transfer Center (ATTC-NE), the New England Institute of Addiction Studies (NEIAS), the Rhode Island Prevention Resource Center (RIPRC), the Drug and Alcohol Treatment Association (DATA), our state colleges and universities, and other community partners to develop and implement new initiatives to support workforce development.

PREVENTION

Early prevention programs often relied on unproven strategies that lacked appropriate evaluation and documentation of results. However, for more than a decade, prevention science has evolved into an ever-increasing number of evidence-based programs and practices. Current prevention programs, policies, and practices continue to evolve and support the science that drives the delivery of evidence-based approaches that address alcohol, tobacco, and other drug (ATOD) problems.

> Prevention is defined as a proactive, multifaceted, multi-community-sector process involving a continuum of culturally appropriate services. It empowers individuals, families, and communities to meet the challenges of life events and transitions by creating and reinforcing conditions that have an impact on physical, social, emotional, spiritual, and cognitive well-being and promote safe and healthy behaviors and lifestyles. Substance abuse prevention is a planned sequence of activities that, through the practice and application of evidence-based programs, policies, and practices, is intended to inform, educate develop skills, alter risk behaviors, and affect environmental factors in addressing alcohol and other drug problems.
>
> (See “An Action Plan for Behavioral Health Workforce Development, prepared by The Annapolis Coalition on the Behavioral Health Workforce (Cincinnati, Ohio) under Contract Number 280-02-0302 with SAMHSA, U.S. Department of Health and Human Services. 2007.)

The growing body of scientific knowledge and use of evidence-based programs have helped to strengthen prevention within the behavioral health field, but this progress has not been without challenges. These changes have placed an increased demands on the workforce that include increased credentialing requirements, the availability of targeted training and skills development, and issues around pay scales.

Rhode Island has documented both strengths and weaknesses of its current substance abuse prevention and treatment system throughout its strategic plan (See Rhode Island Amended Strategic Plan for Substance Abuse Prevention 2013-2015). The RI state action plan for an integrated system of care includes the development of a qualified workforce to meet the unique treatment and prevention needs of individuals with co-occurring disorders. Opportunities exist to explore enhanced infrastructure to increase awareness and capacity among stakeholders within the system, while creating greater integration and efficiency in the system as whole.

There is a need to have greater surveillance of existing providers to better understand the varying levels of readiness and capacity to affect change. A clear opportunity exists to improve workforce development strategies to increase the capacity, knowledge, skills and organizational development of prevention and mental health promotion providers driven by sound practice and data-driven programmatic planning. This includes greater participation in the RI Substance Abuse Prevention Certification system.

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

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

It is important for trainings to match workers' and workplaces' needs to meet core competencies for those in the field and to adequately meet the needs of the people they serve. The RIPRC needs assessment identified eight (8) training content areas needed to increase the capacity of communities to implement, sustain and improve effective prevention initiatives, content areas including: Public Policy and Environmental Change (43%), Prevention Policy Development (37%), Ethics and Confidentiality (37%), Sustainability Planning (34%), Survey Development and Use (31%), Navigating Political Systems (31%), Using Survey Data for Planning and Proposals (29%) and Implementing Focus Groups (29%). The following six (6) key technical assistance needs were also identified: Increasing the Prevention Expertise of Coalition Members (49%), Maximizing Social Media Tools for Prevention (43%), Implementing and Using Needs Assessments (40%) Using Data for Program Improvement (29%), Engaging Key Stakeholders (29%) and Utilizing Asset Building Multidisciplinary Programming (26%).

RIPRC's TTA work plan and deliverables are based on the needs assessment data and focus on an environmental approach to prevention that captures substance use and abuse, but also works to reach the complementary goals of reducing the burden of mental, emotional, and behavioral disorders and promoting healthy development of young people and high risk populations in Rhode Island. Having a findings-based work plan serves to avoid duplication of services, improve access to training opportunities for workforce development, and increase participation in the RI Substance Abuse Certification process.

One of the primary areas of the State's strategic plan includes activities identified to increase participation in the RI Substance Abuse Prevention Certification system, while building on the current substance abuse prevention infrastructure in order to both expand and increase the capacity of the prevention workforce in RI. The RI Substance Abuse Prevention Certification process is currently under-utilized. The primary benefits of certification for individuals and organizations identified by assessment participants includes: meeting the requirements of BHDDH funding, that it documents prevention expertise, and gives the ability to apply for additional state and federal funding opportunities. The primary barriers to achieving RI Prevention Certification include: the process takes too long, collecting required documents is difficult, not sure if the certification is worth the investment and test aversion.

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

CERTIFICATION:

Certification is an important component of workforce development in the field of substance abuse prevention. Certification in the field of substance abuse prevention is based on knowledge in the 6 performance domains that are designed to help the workforce to prevent or reduce the conditions that place individuals at increased risk of substance abuse related issues. As of May 6th, 2014 there are 19 individuals certified as Applied Prevention Specialists (APS), 12 as Certified Prevention Specialists (CPS), and 11 as Certified Prevention Specialist Supervisors (CPSS).

The 2013 Prevention Specialist Job Analysis identified six performance domains and associated tasks for the International Certification & Reciprocity Consortium IC&RC Prevention Specialist Examination:

1. Planning and Evaluation
2. Prevention Education and Service Delivery
3. Communication
4. Community Organization
5. Public Policy and Environmental Change
6. Professional Growth and Responsibility

Each of the 6 domains and their associated tasks are outlined below.

Domain 1: Planning and Evaluation
Associated Tasks:

- Determine the level of community readiness for change.
- Identify appropriate methods to gather relevant data for prevention planning.
- Identify existing resources available to address the community needs.
- Identify gaps in resources based on the assessment of community conditions.
- Identify the target audience.
- Identify factors that place persons in the target audience at greater risk for the identified problem.
- Identify factors that provide protection or resilience for the target audience.
- Determine priorities based on comprehensive community assessment.
- Develop a prevention plan based on research and theory that addresses community needs and desired outcomes.
- Select prevention strategies, programs, and best practices to meet the identified needs of the community.
- Implement a strategic planning process that results in the development and implementation of a quality strategic plan.
- Identify appropriate prevention program evaluation strategies.
- Administer surveys/pre/posttests at work plan activities.

- Conduct evaluation activities to document program fidelity.
- Collect evaluation documentation for process and outcome measures.
- Evaluate activities and identify opportunities to improve outcomes.
- Utilize evaluation to enhance sustainability of prevention activities.
- Provide applicable workgroups with prevention information and other support to meet prevention outcomes.
- Incorporate cultural responsiveness into all planning and evaluation activities.
- Prepare and maintain reports, records, and documents pertaining to funding sources.

Domain 2: Prevention Education and Service Delivery
Associated Tasks:

- Coordinate prevention activities.
- Implement prevention education and skill development activities appropriate for the target audience.
- Provide prevention education and skill development programs that contain accurate, relevant, and timely content.
- Maintain program fidelity when implementing evidence-based practices.
- Serve as a resource to community members and organizations regarding prevention strategies and best practices.

Domain 3: Communication
Associated Tasks:

- Promote programs, services, activities, and maintain good public relations.
- Participate in public awareness campaigns and projects relating to health promotion across the continuum of care.
- Identify marketing techniques for prevention programs.
- Apply principles of effective listening.
- Apply principles of public speaking.
- Employ effective facilitation skills.
- Communicate effectively with various audiences.
- Demonstrate interpersonal communication competency.

Domain 4: Community Organization
Associated Tasks:

- Identify the community demographics and norms.
- Identify a diverse group of stakeholders to include in prevention programming activities.
- Build community ownership of prevention programs by collaborating with stakeholders when planning, implementing, and evaluating prevention activities.
- Offer guidance to stakeholders and community members in mobilizing for community change.

- Participate in creating and sustaining community-based coalitions.
- Develop or assist in developing content and materials for meetings and other related activities.
- Develop strategic alliances with other service providers within the community.
- Develop collaborative agreements with other service providers within the community.
- Participate in behavioral health planning and activities.

Domain 5: Public Policy and Environmental Change
Associated Tasks:

- Provide resources, trainings, and consultations that promote environmental change.
- Participate in enforcement initiatives to affect environmental change.
- Participate in public policy development to affect environmental change.
- Use media strategies to support policy change efforts in the community.
- Collaborate with various community groups to develop and strengthen effective policy.
- Advocate to bring about policy and/or environmental change.

Domain 6: Professional Growth and Responsibility
Associated Tasks:

- Demonstrate knowledge of current prevention theory and practice.
- Adhere to all legal, professional, and ethical principles.
- Demonstrate cultural responsiveness as a prevention professional.
- Demonstrate self-care consistent with prevention messages.
- Recognize importance of participation in professional associations locally, statewide, and nationally.
- Demonstrate responsible and ethical use of public and private funds.
- Advocate for health promotion across the life span.
- Advocate for healthy and safe communities.
- Demonstrate knowledge of current issues of addiction.
- Demonstrate knowledge of current issues of mental, emotional, and behavioral health.

STRATEGIC PLANNING AND WORKFORCE DEVELOPMENT

The Rhode Island State Action Plan for an Integrated System of Care includes the development of a qualified workforce to meet the unique treatment and prevention needs of individuals with co-occurring disorders. The plan was created to take advantage of opportunities to explore enhanced infrastructure to increase awareness and capacity among stakeholders within the system, while creating greater integration and efficiencies of the system as whole.

The goals and objectives of Rhode Island's strategic planning efforts focus around 3 key areas: 1) system-level awareness and capacity; 2) system-level capacity and sustainability; and, 3) local capacity building. The goals and objectives associated with the State's plan become an important component in developing the knowledge, skills, and capacity of those working in the field. Each of these areas is important to developing a workforce that is better able to handle the evolving needs of the prevention provider landscape.

1) Key Area 1: Critical to the State's workforce development efforts include increasing system-level awareness and capacity through:

- Surveillance, evaluation and reporting (Goal 1: Objective 1);
- Communication (Goal 1: Objective 2);
- Training and Technical Assistance (Goal 1: Objective 3); and,
- Leadership development (Goal2: Objectives 1-3).

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

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

a) State-level:
    1. URI, Statewide Evaluation Contract
    2. State Epidemiology Outcomes Workgroup (SEOW)
    3. RI Prevention Resource Center (RIPRC)
        b) RI Substance Abuse Prevention Act (RISAPA) Grantees
        c) Marijuana and Other Drug Initiative (MOD) Grantees

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

Meetings will include and meet as follows:

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

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

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

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

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

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

1) BHDDH Prevention and Planning Unit*
2) Department of Health (HEALTH) and/or Community Violence Prevention and/or Suicide Prevention *
3) RI Substance Abuse Prevention Act (RISAPA) *
4) Mental Healthcare
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
13) Physical Healthcare Provider (s)
14) Parent Organization

15) Law Enforcement
16) Tobacco Control Prevention Specialist(s)
17) Recovery and Treatment
18) Developmental Disabilities
19) RI Department of Education
20) Youth Organizations
21) Mental Health Promotion

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

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

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

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

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

2) Key Area 2: In order to increase capacity and sustainability of the State's prevention and mental health promotion system monitoring and evaluation are critical in determining the effectiveness, sustainability, and cost effectiveness. In particular, process and outcome monitoring becomes key in understanding whether the workforce is being properly developed and the system has a viable, professional workforce. The current plan accomplishes this by:

- Annual reporting of process and outcome measures with recommendations for improvement (Goal 3: Objective 1);
- Developing a plan for long-term system sustainability (Goal 3: Objective 2); and,
- Understanding the feasibility and cost-effectiveness of regionalization of prevention provider networks (Goal 3: Objective 2).

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

Objective I: By December 31st, 2014 (and for each year after) BHDDH will develop an annual report utilizing prevention data to analyze and report on process and outcome measures to determine the effectiveness of the state's prevention and mental health promotion system and to make recommendations for improvement.

Objective II: By December 31st, 2015 BHDDH will develop a sustainability plan (to begin implementation in January of 2016) to specifically outline prevention and mental health promotion programming, policies and initiatives.

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

3) Critical to the State's workforce development efforts also include building local capacity through:

- Increasing the number of certified CPS and CPPS (Goal 4: Objective 1); and,
- Utilizing data-driven program planning (Goal 4: Objective 2, 3)

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

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

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

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

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

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

SAMHA's 2011-2014 Prevention goals include:

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

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

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

Goal 1.4: Reduce prescription drug misuse and abuse.

WORKFORCE DEVELOPMENT ACTION STEPS:

I. Increased availability of training that support improvement of certification rates among prevention providers. Certification of prevention providers helps to ensure that the workforce has core a set of competencies to effectively work within the prevention and mental health promotion system. Ensure trainings are available that are tied to core certification domains will help to increase these core competencies.

   As of December 2013, 26% of RISAPA grantees are Certified Prevention Specialists (CPS) or Certified Prevention Specialist Supervisors (CPSS). The State's strategic plan aims to see this increase to 75% (Goal 4: Objective 1) by December 31st, 2015. Funded providers need to be accountable for increasing the numbers of certified individuals in order to reach this goal. Additionally, it will be important for the State to identify deadlines in moving towards this goal to monitor the increased credentialing of its workforce. If funded providers do not meet established deadlines, BHDDH will need to determine how to make providers accountable. Strategies such as corrective action plans or the withholding of grantee funding for non-compliant providers may be possible options.

II. Increase the utilization of RIPRC TTA services. TTA are critical components of workforce development. Available and accessible TTA are essential to this area. The identification of strategies towards implementation of both in-person and online TTA will help to increase utilization across multiple training modalities.

   Behavioral healthcare providers across multiple disciplines utilize skills that may be transferable, or complimentary to ones' own discipline. The identification of supplemental trainings for topics such as motivational interviewing, monitoring and evaluation, facilitation skills building, recruitment of qualified staff, etc. may be available within complimentary networks of workers. This in turn may assist in having individuals interact outside of programmatic silos. This may also lead to the sharing of salient resources.

III. Implement a training needs assessment every two years. The identification of training and technical assistance that meets the needs of its workforce is critical. A regular assessment of needs helps to

ensure that the training is appropriate and targeted to meet the needs of its workforce. The long-term sustainability of a valid and properly trained workforce depends on it.

IV. Cultivate, acknowledge, and promote prevention experts and content experts to encourage leadership within the field. The identification of leaders across multiple domains within the network of prevention providers is important to promote and effect change. A criterion for what constitutes expert should be developed by BHDDH.

The substance abuse prevention field in Rhode Island has evolved over time. In order to most appropriately and effectively adapt to change, so must its workforce. To increase the capacity and sustainability of the State's prevention and mental health promotion system it is important to thoughtfully and strategically plan for its future. Monitoring and evaluation of key programmatic and workforce initiatives are critical in determining the effectiveness, sustainability, and cost effectiveness of the current system, as well as what potential changes need to be made. Providing and promoting training, technical assistance and capacity building that is adequate and accessible will help to prepare a individuals and organizations to work within this system. And last, opportunities to cultivate leadership to effect and promote change are important to help navigate this evolving system.

Meeting the challenges associated with maintaining a viable workforce is significant. As previously discussed, that includes the recruitment of new employees and the retention of current ones, as the workforce ages into retirement or changes careers. BHDDH is dedicated to the recruitment, retention, education, and training of its substance abuse prevention professionals and to improving the quality of the workforce. Creating and implementing a workplace development plan will support Rhode Island in its efforts to create a more sophisticated prevention workforce that is able to adapt and flourish within an evolving system.