



**Solicitation Information  
June 24, 2016**

**RFP# 7550738**

**TITLE: Regional Prevention Task Forces**

**Submission Deadline: August 5, 2016 at 10:00 AM (Eastern Time)**

**PRE-BID/ PROPOSAL CONFERENCE: No**

Questions concerning this solicitation must be received by the Division of Purchases at [david.francis@purchasing.ri.gov](mailto:david.francis@purchasing.ri.gov) no later than **July 15, 2016 at 10:00 AM (ET)**. Questions should be submitted in a *Microsoft Word attachment*. Please reference the RFP# on all correspondence. Questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

**SURETY REQUIRED: No**

**BOND REQUIRED: No**

**David J. Francis  
Interdepartmental Project Manager**

Applicants must register on-line at the State Purchasing Website at [www.purchasing.ri.gov](http://www.purchasing.ri.gov)

**Note to Applicants:**

Offers received without the entire completed three-page RIVIP Generated Bidder Certification Form attached may result in disqualification.

**THIS PAGE IS NOT A BIDDER CERTIFICATION FORM**

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## **SECTION 1: INTRODUCTION**

The Rhode Island Department of Administration/Division of Purchases, on behalf of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), is soliciting proposals to implement Regional Substance Abuse Prevention Coalitions (RSAPC), as described herein, in accordance with the terms of this Request for Proposals and the State's General Conditions of Purchase, which may be obtained at the Rhode Island Division of Purchases Home Page by Internet at [www.purchasing.ri.gov](http://www.purchasing.ri.gov)

The initial contract period will begin January 1, 2017 for one year. Contracts may be renewed for up to four additional 12-month periods based on vendor performance and the availability of funds.

Funding for this project is contingent on an appropriation from the Substance Abuse and Primary Prevention Block Grant through the United States Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA).

Funding is available to award one project in each of the seven regions: Southern Providence County, Northern Providence County, Providence, Kent County, East Bay, Newport County, and South County (see Appendix VI).

SAMHSA is in the process of creating guidance for states to incentivize performance. The Department reserves the right to add incentive funding in option years of this contract based on guidance from SAMHSA when that becomes available. These incentives, should funding be available, will be based upon the scope of work and performance measures within this RFP. Any incentives will be negotiated with the awardees of this RFP and executed within a contract amendment.

This is a Request for Proposals, not an Invitation for Bid. Responses will be evaluated on the basis of the relative merits of the proposal, in addition to price; there will be no public opening and reading of responses received by the Division of Purchases pursuant to this Request, other than to name those offerors who have submitted proposals.

### **INSTRUCTIONS AND NOTIFICATIONS TO OFFERORS:**

1. Potential vendors are advised to review all sections of this RFP carefully and to follow instructions completely, as failure to make a complete submission as described elsewhere herein may result in rejection of the proposal.
2. Alternative approaches and/or methodologies to accomplish the desired or intended results of this procurement are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this RFP will be rejected as being non-responsive.
3. All costs associated with developing or submitting a proposal in response to this RFP, or to provide oral or written clarification of its content shall be borne by the vendor. The State assumes no responsibility for these costs.

4. Proposals are considered to be irrevocable for a period of not less than 60 days following the opening date, and may not be withdrawn, except with the express written permission of the State Purchasing Agent.
5. All pricing submitted will be considered to be firm and fixed unless otherwise indicated herein.
6. Proposals misdirected to other state locations, or which are otherwise not present in the Division at the time of opening for any cause will be determined to be late and will not be considered. For the purposes of this requirement, the official time and date shall be that of the time clock in the reception area of the Division.
7. It is intended that an award pursuant to this RFP will be made to a prime vendor, or prime vendors in the various categories, who will assume responsibility for all aspects of the work. Joint venture and cooperative proposals will not be considered. Subcontracts are permitted, provided that their use is clearly indicated in the vendor's proposal and the subcontractor(s) to be used is identified in the proposal.
8. All proposals should include the vendor's FEIN or Social Security number as evidenced by a W9, downloadable from the Division's website at [www.purchasing.ri.gov](http://www.purchasing.ri.gov).
9. The purchase of services under an award made pursuant to this RFP will be contingent on the availability of funds.
10. Vendors are advised that all materials submitted to the State for consideration in response to this RFP will be considered to be Public Records as defined in Title 38, Chapter 2 of the General Laws of Rhode Island, without exception, and will be released for inspection immediately upon request once an award has been made.
11. Interested parties are instructed to peruse the Division of Purchases website on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this RFP.
12. Equal Employment Opportunity (G.L. 1956 § 28-5.1-1, et seq.) – § 28-5.1-1 Declaration of policy – (a) Equal opportunity and affirmative action toward its achievement is the policy of all units of Rhode Island state government, including all public and quasi-public agencies, commissions, boards and authorities, and in the classified, unclassified, and non-classified services of state employment. This policy applies to all areas where State dollars are spent, in employment, public services, grants and financial assistance, and in state licensing and regulation.
13. In accordance with Title 7, Chapter 1.2 of the General Laws of Rhode Island, no foreign corporation, a corporation without a Rhode Island business address, shall have the right to transact business in the State until it shall have procured a Certificate of Authority to do so from the Rhode Island Secretary of State (401-222-3040). This is a requirement only of the successful vendor(s).
14. The vendor should be aware of the State's Minority Business Enterprise (MBE) requirements, which address the State's goal of ten percent (10%) participation by

MBE's in all State procurements. For further information visit the website [www.mbe.ri.gov](http://www.mbe.ri.gov)

15. Under HIPAA, a “business associate” is a person or entity, other than a member of the workforce of a HIPAA covered entity, who performs functions or activities on behalf of, or provides certain services to, a HIPAA covered entity that involves access by the business associate to HIPAA protected health information. A “business associate” also is a subcontractor that creates, receives, maintains, or transmits HIPAA protected health information on behalf of another business associate. The HIPAA rules generally require that HIPAA covered entities and business associates enter into contracts with their business associates to ensure that the business associates will appropriately safeguard HIPAA protected health information. Therefore, if a Contractor qualifies as a business associate, it will be required to sign a HIPAA business associate agreement
  
16. In order to perform the contemplated services related to the Rhode Island Health Benefits Exchange (HealthSourceRI), the vendor hereby certifies that it is an “eligible entity,” as defined by 45 C.F.R. § 155.110, in order to carry out one or more of the responsibilities of a health insurance exchange. The vendor agrees to indemnify and hold the State of Rhode Island harmless for all expenses that are deemed to be unallowable by the Federal government because it is determined that the vendor is not an “eligible entity,” as defined by 45 C.F.R. § 155.110.

## **SECTION 2: BACKGROUND**

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals' (BHDDH) Division of Behavioral Healthcare (DBH), is the state mental health authority and the co-single state authority for substance use and primary prevention which authorizes the Department to administer the Substance Abuse Block Grant and apply for discretionary funds from the Substance Abuse and Mental Health Services Administration (SAMHSA). DBH is responsible for policy, planning and ensuring quality services for individuals with mental health and substance use disorders, as well as, sustaining a system for primary prevention. The Division also administers the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant, which includes conducting community-wide needs assessments, identifying gaps in the continuum of services and developing a statewide plan to address identified issues and gaps in the system.

BHDDH administers a portion of the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant from SAMHSA to implement evidence-based substance misuse prevention programs, practices, policies and approaches within the state. The federal block grant guidelines include primary prevention activities that refer to a proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles. Primary prevention includes interventions, occurring prior to the initial onset of a substance use disorder, through reduction or control of factors causing substance abuse, including the reduction of risk factors contributing to substance use. Services are delivered through six, defined, federal strategies listed below. Each

region will need to demonstrate that programming and funding will cover five of six services areas delivered within the region (not necessarily within each community) through the defined federal strategies listed below:

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

The department's prevention system has consisted of three major components: municipal task forces (coalitions), student assistance programs established by legislation; and community-based programs, largely curricular in nature, all funded with federal dollars.

Historically, there have been 35 municipal level substance abuse prevention task forces charged with planning and coordinating of a comprehensive substance prevention programming within the community. The municipal task forces were established under RI General Laws 16-21.2-1 "The Rhode Island Substance Abuse Prevention Act." The financial assistance was drastically reduced in various budget cycles and eliminated from the state budget at the end of fiscal year 2014, forcing all prevention activities to be funded through the Substance Abuse Block Grant.

This regionalization is intended to achieve some economies of scale, reduce operating costs, streamline operations and improve outcomes on state identified priorities using evidence based and best practices covering five (5) of six (6) prevention strategies authorized by SAMHSA/Center for Substance Abuse Prevention in RI's cities and towns. This procurement seeks to enhance the ability of local coalitions to implement evidence-based practices designed to engage communities and attain population level changes in consumption patterns. The purpose of this RFP is to provide regionalized coordination, which will increase the capacity of the local community task forces, while promoting efficiencies in process and improved outcomes. A secondary goal is to promote a lifespan approach, encourage collaboration across the continuum of care among multiple stakeholder groups concerned with behavioral health and to leverage federal and private dollars to address local behavioral health priorities.

BHDDH utilizes a multi-year strategic planning process to set substance prevention priorities throughout the state. The Amended Strategic Plan for Substance Abuse Prevention 2016-2019 is

included in this Request, see Appendix III The Regional Substance Abuse Prevention Coalitions (RSAPC), will create a regional work plan which will describe the best practices and evidence based practices that will be employed at the municipal level to address the priority problems identified in the state's substance abuse prevention strategic plan. The regional plan will draw information from a set of municipal needs and resource assessments to create a set of regional priority needs. BHDDH, through a training and technical assistance contractor, will provide support tools for assessment of community needs and resources. Each municipality will have the ability to select a set of evidence informed or evidence based practices that is congruent with the culture and context of their community

Eligible applicants for this procurement are community-based, non-profit organizations, charitable organizations, units of local government, and private and public colleges and universities. For-profit organizations are not eligible to receive funding through this procurement. Applicants applying for funding through this RFP must have a smoke-free workplace policy in place in all facilities. Improving cultural and linguistic competence is an important strategy for addressing persistent behavioral health disparities experienced by diverse communities, including lesbian, gay bisexual, and transgender populations as well as racial and ethnic minority groups. These diverse populations tend to have less access to prevention services and poorer behavioral health outcomes. The successful applicant(s) will need to demonstrate adherence to standards for Culturally and Linguistically Appropriate Services as defined by the Office of Minority Health. (Cultural competence webpage <http://www.samhsa.gov/capt/applying-strategic-prevention/cultural-competence>). With this procurement the Department looks to enhance and expand its commitment to use the Strategic Prevention Framework (SPF). The SPF reflects a community-based approach to prevention efforts and helps states, tribes, and jurisdictions build the infrastructure necessary for successful outcomes. Each step contains specific tasks and key milestones.

The steps of the SPF include:

Step 1: Assess Needs

Step 2: Build Capacity

Step 3: Plan

Step 4: Implement

Step 5: Evaluation

- All applicants are required to demonstrate the stability of their organization, effective management and administrative performance including: Evidence of organizational structure: overall mission, program, and services, indicating how they relate to the goals and priorities described in Section 3 of the RFP. Describe resources, management, and fiscal capabilities sufficient to implement the proposed project and provide accountability that supports or complements the services in this RFP.
- Technical capacity (computer and electronic communication): It is essential that the vendor have direct access to the Internet. The offeror needs the staff and technological capacity to submit data and reports electronically via the Internet.

- Appropriate staff with documented prevention-related credentials and experience to implement the program. The applicant will be expected to examine what job skills the selected programs require and ensure that staff has the needed skills. At least one full-time staff person is required to be in place within one month of start-up. The proposed Regional Coordinators must be at minimum, an Associate Prevention Specialist (APS) and obtain the Certified Prevention Specialist (CPS) credential within a year of award. The proposed Regional Coordinator must be approved by the department. Please note, year 2 funding, if available, may incentivize regions whose Coordinator has obtained the Certified Prevention Specialist Supervisor (CPSS).
- Evidence that this offeror has, alone or in partnership with other community organizations and groups, the experience and capacity to mount a Regional Substance Abuse Prevention Coalition Initiative and implement population level outcomes. Provide a description of partner organizations or groups, past working relationships and how the composition of the partnership will facilitate the development of a Comprehensive Community Initiative. If applying as a single agency, describe how such development will be possible.
- Experience in all aspects of technical writing (reports, assessments, grant writing, evaluations, comprehensive prevention planning) and the ability to provide both training and technical assistance for this skill.
- An office based within the Region applying (if the vendor does not have a regional office at the time of application, they must establish one within 60 days of the effective date of award).
- Experience in coalition-building, comprehensive substance abuse prevention planning, evaluation, and assessment.
- Written agreement to participate in all aspects of the evaluation as specified by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.

The department WILL NOT accept applications proposing to serve more than one region. Applicants seeking to serve more than one region MUST submit separate, complete applications for each region. **Combined regional applications will not be considered.**

## **SECTION 3: SCOPE OF WORK**

### **General Scope of Work**

Substance use disorders have a serious impact on the quality and function of the lives of individuals, the strength of family support systems and community organization and attachment. Devastating consequences of substance use disorders range from increased violence in homes and academic difficulties for youth to car crashes and life-threatening overdoses. Substance use and mental health disorders can prevent individuals from reaching a state of personal health or “whole” health. In comparison to national figures, Rhode Island’s substance abuse rates and general mental health issues are statistically higher for a number of populations. Furthermore, research has shown that community coalitions can be effective agents for public health promotion and can reduce negative outcomes associated with behavioral health problems when community stakeholders are actively engaged and culturally-appropriate, evidence-based practices are implemented. This solicitation seeks to establish a sustainable network of community prevention coalitions whose focus is to identify and leverage resources to address behavioral health needs within Rhode Island cities and towns, including promoting wellness as part of mental health promotion.

BHDDH is proposing to offer funding to seven (7) regions to provide comprehensive substance abuse prevention and behavioral health promotion services. The regions as they are proposed have taken into account the feedback from the December 30, 2015 Request for Information (RFI) #7550120 and tries to balance the number of municipalities served; keeps regionalized school districts within a single region (for example, Charliho, Foster/Glocester, and Exeter/West Greenwich); and retains existing regional cultural identities such as East Bay, West Bay and greater Blackstone Valley. These regions would include Western Providence County (region 1), Eastern Providence County (region 2), City of Providence (region 3), Central RI/West Bay (region 4), East Bay (region 5), Newport County (region 6) , and South County (region 7). See Map for configuration of regions, Appendix VI. Only one of these regions, Providence, is a single municipality. Providence was separated from the other regions because the US Census Bureau treats it as a Standard Metropolitan Statistical Area and reports statistics in a way that compares Providence to the rest of the state and to other metropolitan areas.

The revitalized system for prevention will be composed of a regional prevention coalition which is primarily responsible for overseeing the planning and delivery of prevention activities within the municipalities that comprise the region. The regional coalition will be comprised of multiple municipal substance abuse prevention coalitions who retain their individual identity and continue to provide prevention services to their communities. The newly-developed regional prevention coalition will provide administrative oversight, funding and other human, technical or financial resources needed to support municipal task force contributions to a regional prevention plan, and it will act as the fiduciary and administrative agent.

Regional Substance Abuse Prevention Coalitions (RSAPC) will be asked to use funding for three priorities: (1) To increase the use of evidence-based policies, practices and programs by municipal substance abuse prevention coalitions across the lifespan, as well as among various sectors and community stakeholders (schools, law enforcement, prescribers of opioid medications) based on the findings of the municipal needs assessments;(2) Implement

environmental change strategies to raise awareness of potential for harm, and reduce youth access to harmful legal products (e.g., products which might be legal for use by a segment of the population such as adults but which are not legal and are potentially harmful to others such as youth), and (3) Use media and communication strategies to promote positive behavioral health, increase the perception of risk or harm from substance use and correct normative misunderstandings of the norm among youth and young adults (e.g., everyone drinks alcohol).

Each Regional Prevention Coalition will set aside a percentage of their direct cost budget to manage a performance-based incentive fund for municipal members. In addition, each Regional Prevention Coalition will provide funding for incentives.

## **TASKS**

The Regional Prevention Coalitions tasks and related activities covered within this scope of work are described below.

### **Task 1 – Regional Prevention Coalition Formation, Organizational Development and Partnership Development (timeline for completion - 90 day from effective date of contract)**

1. Identify key staff for the regional coalition including the regional coordinator and fiduciary agent
2. Determine roles and responsibilities associated with the municipal coalitions that comprise their regional membership
3. Engage representatives of all communities within region to serve on the Regional Board with a signed Memorandum of Understanding or Cooperative Agreement.
4. Develop policies, protocols and procedures and decision making processes for the regional coalition and members
5. Hire municipal substance abuse prevention coalition coordinators for communities within the region (if needed)
6. Convene the membership on a monthly, or more frequent basis, to identify shared needs and shared resources within the region as part of the planning process
7. Develop a transparent process for performance-based contracting and the use of incentives for members who meet or exceed selected performance targets established by the state
8. Attend at BHDDH planned meetings throughout the duration of the contract period (Regional Coordinator). Meetings may be held as frequently as monthly during years 1 & 2 of funding and quarterly thereafter.
9. Participate in required training and technical assistance sessions. In year 1 of the contract, up to 10 days of training or technical assistance sessions may be required for the Regional Coordinator.

**Task 2 – Conduct Regional and Municipal Needs Assessments (up to 180 days from EDOC)**

1. Identifying specific types of support needed by the municipal coalitions to conduct activities described in this solicitation
2. Provide support and leverage resources to support the conduct of municipal/local needs assessments
3. Identify shared regional needs and resources within the region
4. Create a regional needs assessment informed by key findings across municipal/local needs assessments
5. Similarly, regional coalition leadership will develop regional priorities for training and technical assistance (TTA) and work collaboratively to obtain needed TTA through BHDDH's TTA contractor

**Task 3 – Create Regional Strategic Plans and Municipal Work Plans Addressing State Identified Priority Problems (Includes Capacity Building Plans) (up to 180 days from EDOC)**

1. Facilitating the development of the regional plan
2. Assist the member municipal coalitions with the development of a municipal multi-year work plan based on their regional needs and priorities
3. Providing an annual work plan with projected regional and municipal deliverables and time frames

**Task 4 – Implement, Monitor, Evaluate and Sustain Activities within Regional Prevention Strategic Plan and Municipal Work Plans (ongoing after 180 days and option years 2-5 if funding is available)**

The Regional Coordinators will be responsible for working with the local communities to develop regional strategic plans with measurable plans that include the Division's priorities. Key activities associated with this task include:

1. Implement the regional strategic plan, which must include:
  - a. Implementation of four of the six CSAP prevention strategies within the region (*Please note that problem identification & referral is being addressed through another contract. The regional prevention coalitions need not propose to address this CSAP strategy.*)
  - b. Implementation of the Rhode Island Student Survey among municipalities represented within the region where the RISS is not currently administered
2. Dissemination of funds to municipal substance abuse task forces to implement pilot programs addressing priorities from the regional plan. Municipal work plans which must include:
  - a. Use of Evidence-based Practices. Please visit the SAMHSA's National Registry of Evidence Based Programs and Practices at <http://nrepp.samhsa.gov/>
  - b. Data collection, analysis and data management
  - c. Strategies intended to reduce youth access to tobacco products as prescribed in Appendix IV (Synar Amendment Compliance)

3. Contract management, including the role of the region lead in managing the work of the local task forces and coordinating regional activities based on contract deliverables and performance measures as described in Appendix II
4. Development of a quality assurance protocol and associated policies and procedures
5. Identification and use of compliance tools
6. Monitoring progress on the municipal multi-year work plan based on performance measures
7. Enter data is entered in the Mosaix IMPACT prevention platform on a monthly basis for all communities in the region
8. Participating in process and outcome evaluation
9. Providing quarterly narrative reports to BHDDH to document both regional and local/municipal progress on the regional plan.
10. Report progress and outcomes to BHDDH and key stakeholders
11. Provide assistance with fund development and grant writing to members as part of sustainability support and sustainability planning
12. Other tasks related to the emerging needs funding set-aside as determined by BHDDH

The Regional Prevention Coalition (RPC) will be required to build capacity by ensuring inclusive sector coverage from each community within the region including key stakeholders in the region from each of the six required sectors. This will be measured in the prevention data collection system IMPACT.

The RPC will identify at least one evidence based individual and environmental strategy and program. The reach and dose would create change in knowledge, attitudes or behaviors across the lifespan with a measurable increase in the percent of in-school, school-aged youth expressing disapproval of use alcohol, tobacco, and other drugs (ATOD) by 10%. This will be measured by data entered into the RI Student Survey.

The Department will require administration of the RI Student Survey. Administration of a school-based survey requires approval of the local educational agency (LEA). The Department is committed to working with the awardees to secure approval from the LEA and SEA.

80% of the middle and high schools in each community within the region must commit to conducting the online survey. Once the survey is started, it must be completed within 30 school days.

*The incidence and prevalence survey will require active consent of the parents/guardians of the participants and active assent of the survey participants, unless determined otherwise by the LEA. The survey proposed by the Department will be submitted by the independent evaluator to the appropriate IRB and obtain all necessary approvals, if necessary.*

In year two we expect a reduction in consumption patterns. RSAPC communities must show a measurable reduction in the percent of in-school, school-aged youth reporting current (past 30-day) use of ATOD by 3%. This will be measured by the RI Student Survey.

The Department will employ an independent, external evaluator who will evaluate project implementation and outcomes. Applicants must designate a staff member as liaison to the Department's evaluation team and must participate in the Statewide Evaluation.

### **Task 5 - Special Enhancement Activities as Needed**

In addition to the tasks identified above, should additional funding become available the State reserves the option to direct the regions to conduct additional tasks to support the overall scope of this project. It is critical that the state have the flexibility to bring on additional technical assistance and expertise, in a timely manner, in order to perform activities which require similar expertise and work functions as those in Section 3: Scope of Work.

The decision to use services under this Special Enhancement will be solely at the State's request, and will be for specific enhanced activities not already included under the RFP. These optional activities will be defined, and agreed to in writing, by both the State and the vendor, before any enhanced work begins. There is no commitment on the part of the State to use any or all special projects/enhanced activities. All bidders must bid on the Special Enhancement using the hourly rates established in the award. Tasks should be bid and paid on a fully-loaded, time and materials basis for all personnel and subcontractors used to complete the optional task(s). This work must, support but not duplicate, the work described in the technical proposal's scope of work. This work cannot exceed 10% of the initial award. Should new funding become available the Purchasing Agent would need to authorize payments in excess of 10% of the contract for special enhancements. The awarded vendor shall not perform any special enhanced activities without receiving a formal change order issued by the Division of Purchases.

### **Roles and Responsibilities of Regional and Municipal Prevention Coordinators**

#### ***Regional Prevention Coordinator***

Please note that these funds will offset contracted services or salary and benefits at an hourly rate range as described in Table 1 for a Regional Prevention Coordinator (RPC).

- Identify shared needs and resources within the region
- Advocate for needed resources within the region including human, technical and financial resources based on municipal/community needs and resource assessment
- Leverage needed resources within the region and within individual municipalities including human, technical and financial resources
- Assist municipal substance abuse prevention coalitions (task forces) in creating municipal (local) work plans based on a comprehensive municipal needs and resources assessment
- Assist municipal prevention coalitions in creating a multi-year funds development and fund diversification plan
- Enter data related to progress in the implementation of the regional strategic plan and the annual municipal work plans into the Mosaix IMPACT prevention platform

- RPCs will report and monitor progress in achieving goals and objectives related to the regional prevention plan and individual municipal prevention plans
- RPCs will oversee activities of all of the community prevention coalitions within their region to insure that there is coordination of efforts, activities and available resources
- Convene the members of the region, including all municipal prevention coalition coordinators, as a regional prevention coalition to meet on a monthly basis for the duration of the award
- RPCs will provide documentation and reports, with frequency and in the format to be determined by BHDDH, detailing funded activities within the region including those being implemented at the municipal level
- Participate in a statewide evaluation designed to measure impact on substance related problems
- Implement municipal compliance with federal Synar Regulation requirements including monitoring the implementation of eligible prevention strategies and activities.

Municipal or community input is necessary to insure that the wide variety and range of needs across RI cities and towns can be properly addressed using strategies and interventions appropriate to the culture and the context of the community in which they are implemented. This solicitation represents broader and deeper behavioral health planning activities requiring some transition from the “old” substance abuse prevention coalitions to the “new” community prevention coalitions with an expanded behavioral health focus. The expanded focus will require the engagement of new stakeholders, community leaders and champions. To this end, there must be limited financial support for a local community prevention coalition coordinator who will bear responsibility for guiding efforts during this transition. If funding is available, the level of financial support provided by these funds will be stepped down for each year of the award as the Regional Prevention Coalition provides assistance in creating a fund development plan that incrementally decreases reliance on these funds and diversifies funding derived from other revenue streams such foundations, other types of grants, fund raising, planned giving and collaboration/coordination with other community social service providers focused on the consequences of negative behavioral health outcomes.

The funding strategy to support the work of the municipal prevention coalition coordinator will feature a 10% step down for each year between 2 and 5 (if funding is available) to provide some stability to support transition in the focus and work of the coalitions. It is intended that these funds, over time, will only provide a portion of the funding to support the municipal prevention coalition coordinator with the remainder of funding coming from a more diversified stream of funds.

Ultimately, the bulk of the funds that go to the municipal prevention coalition will be used to provide “seed” funding for piloting evidence-based practices among partners from the six core sectors based on the assessment of the municipal needs and resources. For option periods 2-5 (years 2-5), if funding is available, the municipality, in coordination with the other members in the region and the regional prevention coordinator, will identify a priority sector/partner to

receive funding to pilot an evidence-based practice, policy or program to address needs identified during the planning process in the year 1.

*Year 1 – Base Year Funding for Municipal Prevention Coalition Coordinator*

Funds will be made available through the Regional Prevention Coalition to support a municipal community prevention coordinator through the point of completing a municipally-focused community prevention plan and early implementation of the plan. These funds are based on the population of the community (this can range between .25 and 1.0 FTE depending on available resources within the region). The municipal prevention coordinator’s responsibility will be to coordinate the implementation of the municipal prevention needs assessment, the identification of capacity building needs along with an approach to address these needs, and the development of a municipal work plan for a three –five year cycle.

*Year 2 – 10% Step Down from Base Year*

Funding to support a municipal community prevention coordinator will be reduced by 10% as the focus of community activities will be partnering with stakeholders to implement the activities and evidence-based practices contained in the municipal work plan. The Regional Prevention Coalition will be charged with assisting the municipal prevention coalition coordinator in developing a multi-year funds development plan to offset the reduction in financial resources as described below.

*Years 3 to 5 with 10% additional steps downs each year*

- Year 3 - Funding to support the above-referenced coordinator will be reduced by an additional 20%, being 30% less than the funding available in year 1
- Year 4 - Funding to support the above referenced coordinator will be reduced by an additional 10%, being 40% less than the funding available in year 1
- Year 5 - Funding to support the above referenced coordinator will be reduced by an additional 10%, being 50% less than the funding available in year 1

***Municipal Prevention Coalition Coordinator***

- Identify municipal stakeholders across the six core sectors, behavioral health foci and continuum of care
  - Business
  - Education
  - Safety
  - Medical/health
  - Government
  - Community/family supports
- Develop a municipal recruitment and retention plan for the six core sectors
- Recruit and engage multiple municipal representatives of the six core sectors
- Facilitate at least 10 meetings a year of the municipal prevention coalition

- Assess municipal needs and resources using a standard assessment protocol provided by the Regional Prevention Coalition
- Develop a multi-year municipal prevention plan in collaboration with the Regional Prevention Coordinator
- Develop annual work plans detailing the approach described in the municipal prevention plan for the period of the award
- Identify at least one partner among the six core sectors with the requisite readiness and capacity to implement a pilot, evidence-based practice each year for years 2-5 and assist them with developing a plan to sustain or expand the pilot if the initial implementation is successful
- Implement a multi-year funds development plan for the municipal task force as described above

#### **SECTION 4: TECHNICAL PROPOSAL**

Narrative and format: The separate technical proposal should address specifically each of the required elements:

1. **Staff Qualifications** – Please provide: a detailed job description including qualifications as described in this proposal, staff resumes/CV, description of qualifications and experience of key staff including their experience with the provision of community based prevention services. Please address the proposed Regional Prevention Coordinator’s experience with specific key tasks and activities as described in the Scope of Work above.
2. **Capability, Capacity, and qualifications of the Offeror** – The Offeror may be a 501(c) 3 or a government entity. Please provide a detailed description of the Vendor’s experience in project and fiscal management as well as other experience that would inform your ability to provide the services listed above. Letters of Commitment from all partnering municipal substance abuse prevention task forces within region must be included in the appendix to this proposal.
3. **Work plan** - Please describe in detail, the framework within which requested services will be performed. The following elements must be included: 1) timeline for implementing the strategies of this RFP 2) ability to create a regional strategic plan that incorporates both state and local priorities, 3) potential tools used to achieve performance based outcomes, compliance, contract management, 4) data collection and analysis or ability to work within the state evaluation. Please describe the how Tasks 1-4 will be accomplished within the time frames proposed in the Scope of Work.
4. **Sustainability of Approach/Leveraging Resources** –Please describe the region’s ability to leverage both financial and other community resources to implement a public health approach including access to local educational authorities, mental health and treatment providers and other preventative services. It is the Department’s expectation that the Regional Substance Abuse Prevention Coalitions demonstrate a capacity to leverage a

minimum of 20% of the budget from local resources including in-kind and program dollars in option years 2-5 (if funding is available) and earlier than the option years if this possible. Please provide letters of commitment for the funding leveraged, these letters should describe the types of funding leveraged but **SHOULD NOT** include the amounts. The amounts will be listed in cost proposals which will only be seen for those applicants that pass the technical proposal scoring minimum requirements.

## **SECTION 5: COST PROPOSAL**

Detailed Budget and Budget Narrative:

Provide a proposal for fees charged for the services outlined in this proposal. Please use the Budget format from Appendix VII to submit a line item budget reflecting costs to be charged to any resulting contract.

**PROPOSED FUNDING FORMULA** – The funding methodology is population based with maximum awards of \$150,000 and minimum awards of \$10,000 per municipality. Providence region is not eligible for a regional coordinator since the city itself is a region and therefore will be capped at \$150,000. The formula is based on \$1.42 per resident within the region according to the 2015 population estimates from the United States Census Bureau. If available, Year 2 funding may be altered based on the Needs Assessment and data from the State Epidemiological Profile. Municipal coalitions may receive an enhancement/increase to their annual award if they exceed performance measures related to timeliness of data entry into Mosaix IMPACT, saturation of CSAP strategies within the municipality, number of schools within a school district that participate in the RI Student Survey, and percentage of municipal coordinators who attain and maintain prevention certification. An additional incentive would be provided directly to the regional coordinator if certification at the level of Certified Prevention Specialist Supervisor is attained and maintained for the duration of the contract if funding for this incentive is available and approved by the Department of Purchasing. Issuance of these incentives will take place during the contract year but not later than third quarter and must be approved by the department.

Please refer to Table 1 below for guidance on compensation ranges for Regional Prevention Coordinators and Municipal Prevention Coordinators. It contains suggested hourly rate ranges for municipal and regional prevention coalition coordinators based on level of certification, relevant prevention experience and educational backgrounds. Compensation outside of this suggested range is permissible but must be justified within the budget narrative.

The cost proposal must be accompanied by a budget narrative describing calculations and justification for expenditures. The budget narrative should also describe any in-kind contributions or complimentary funding resources. An indirect expense may be requested but an amount greater than 10% may only be requested if Provider has a federally approved indirect rate which can only be used for programming funded by SAMHSA funds, i.e. it can only be requested on the SAMHSA-funded portion of the direct charges.

**TABLE 1 – Suggested Hourly Rate Range for Prevention Coordinators**

| Hourly rate range               |                    |                   | Hourly rate range               |                    |                   | Hourly rate range                          |                    |                   |
|---------------------------------|--------------------|-------------------|---------------------------------|--------------------|-------------------|--|--------------------|-------------------|
| 17- 18                          | 18-19              | 19-20             | 20-22                           | 22-26              | 26-30             | 30-32                                      | 32-34              | 34-38             |
| Certification Level             |                    |                   | Certification Level             |                    |                   | Certification Level                        |                    |                   |
| Associate Prevention Specialist |                    |                   | Certified Prevention Specialist |                    |                   | Certified Prevention Specialist Supervisor |                    |                   |
| Relevant Prevention Experience  |                    |                   | Relevant Prevention Experience  |                    |                   | Relevant Prevention Experience             |                    |                   |
| 0-3 yrs                         | 3-5yrs             | 5+ yrs            | 0-3 yrs                         | 3-5yrs             | 5+                | 0-3 yrs                                    | 3-5yrs             | 5+                |
| Educational Background          |                    |                   | Educational Background          |                    |                   | Educational Background                     |                    |                   |
| Less than Associate Degree      | Associate or Above | Bachelor or Above | Less than Associate Degree      | Associate or Above | Bachelor or Above | Less than Associate Degree                 | Associate or Above | Bachelor or Above |

Please note that these funds will offset contracted services or salary and benefits up to \$60,000 annually for a Regional Prevention Coordinator. Compensation level for the Regional Prevention Coordinator which exceed this level are allowable with matching funds. Similarly, budgets which propose compensation levels above the recommended levels for Municipal Prevention Coordinators will be considered with sufficient justification or matching funds.

Also see Appendix IV which identifies funding levels for each municipality within the region available to support municipal level activities.

Please be sure to describe how municipal funds will be distributed in base year (Year 1) and the option years and insure that the step down in funding for municipal coordinator compensation is addressed in the budget narrative.

**Project cost** - The lowest responsive bidder will receive one hundred percent (100%) of the available points for cost. All other bidders will be awarded cost points based upon the following formula:

$$(\text{low bid} / \text{vendor's bid}) * \text{available points}$$

For example: If the low bidder (Vendor A) bids \$65,000 and Vendor B bids \$100,000 for monthly cost and service fee and the total points available are Fifteen (15), vendor B's cost points are calculated as follows:

$$\$65,000 / \$100,000 * 15 = 9.75$$

**Leveraged Funds** - The bidder with the most dollars leveraged will receive one hundred percent (100%) of the available points for cost. All other bidders will be awarded subcontractor points based on the following formula:

$$(\text{Vendor's bid} / \text{most dollars leveraged}) * \text{available points}$$

For example if the bidder with the most dollars leveraged (Vendor A) has \$100,000 in subcontracts and Vendor B has 500,000 in dollars leveraged and the total points available are fifteen (15), vendor B's points are calculated as follows:

$$\$50,000/100,000 * 15 = 7.5$$

**SECTION 6: EVALUATION AND SELECTION**

Proposals will be reviewed by a Technical Review Committee comprised of staff from state agencies. To advance to the Cost Evaluation phase, the Technical Proposal must receive a minimum of 60 (85.7%) out of a maximum of 70 technical points. Any technical proposals scoring less than 60 points will not have the cost component opened and evaluated. The proposal will be dropped from further consideration.

Proposals scoring 60 technical points or higher will be evaluated for cost and assigned up to a maximum of 30 points in cost category, bringing the potential maximum score to 100 points. The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals reserves the exclusive right to select the individual(s) or firm (vendor) that it deems to be in its best interest to accomplish the project as specified herein; and conversely, reserves the right not to fund any proposal(s).

Proposals will be reviewed and scored based upon the following criteria:

| <b>Criteria</b>   | <b>Possible Points</b> |
|---|------------------------|
| Staff Qualifications:   | 15 Points              |
| Capability, Capacity, and Qualifications of the Offeror   | 20 Points              |
| Quality of the Work plan  | 20 Points              |
| Sustainability of Approach/Leveraging Resources   | 15 Points              |
| <b>Total Possible Technical Points</b>  | <b>70 Points</b>       |
| The lowest responsive bidder will receive one hundred percent (100%) of the available points (15) for cost. All other bidders will be awarded cost points based upon the following formula See below *                        | 15 Points              |
| The bidder with the most dollars leveraged will receive one hundred percent (100%) of the available points (15) for cost. All other bidders will be awarded subcontractor points based on the following formula, See below ** | 15 points              |
| <b>Total Possible Points for Cost</b>   | <b>30 Points</b>       |
| <b>Total Possible Points</b>  | <b>100 Points</b>      |

\*The lowest responsive bidder will receive one hundred percent (100%) of the available points for cost. All other bidders will be awarded cost points based upon the following formula:

$$(\text{low bid} / \text{vendor's bid}) * \text{available points}$$

For example: If the low bidder (Vendor A) bids \$65,000 and Vendor B bids \$100,000 for monthly cost and service fee and the total points available are Fifteen (15), vendor B's cost points are calculated as follows:

$$\$65,000 / \$100,000 * 15 = 9.75$$

\*\*The bidder with the most dollars leveraged will receive one hundred percent (100%) of the available points for cost. All other bidders will be awarded subcontractor points based on the following formula:

$$(\text{Vendor's bid} / \text{most dollars leveraged}) * \text{available points}$$

For example if the bidder with the most dollars leveraged (Vendor A) has \$100,000 in subcontracts and Vendor B has 500,000 in dollars leveraged and the total points available are fifteen (15), vendor B's points are calculated as follows:

$$\$50,000 / 100,000 * 15 = 7.5$$

Points will be assigned based on the offeror's clear demonstration of his/her abilities to complete the work, apply appropriate methods to complete the work, create innovative solutions and quality of past performance in similar projects.

Applicants may be required to submit additional written information or be asked to make an oral presentation before the technical review committee to clarify statements made in their proposal.

## **SECTION 7: PROPOSAL SUBMISSION**

Questions concerning this solicitation may be e-mailed to the Division of Purchases at [david.francis@purchasing.ri.gov](mailto:david.francis@purchasing.ri.gov) no later than the date and time indicated on page one of this solicitation. Please reference **RFP# 7550738** on all correspondence. Questions should be submitted in a Microsoft Word attachment. Answers to questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information. If technical assistance is required to download, call the Help Desk at (401) 574-9709.

Offerors are encouraged to submit written questions to the Division of Purchases. **No other contact with State parties will be permitted.** Interested offerors may submit proposals to provide the services covered by this Request on or before the date and time listed on the cover page of this solicitation. Responses received after this date and time, as registered by the official time clock in the reception area of the Division of Purchases will not be considered.

Responses (**an original plus four (4) copies**) should be mailed or hand-delivered in a sealed envelope marked “**RFP# 7550738 Regional Prevention Task Forces**” to:

RI Dept. of Administration  
Division of Purchases, 2nd floor  
One Capitol Hill  
Providence, RI 02908-5855

NOTE: Proposals received after the above-referenced due date and time will not be considered. Proposals misdirected to other State locations or those not presented to the Division of Purchases by the scheduled due date and time will be determined to be late and will not be considered. Proposals faxed, or emailed, to the Division of Purchases will not be considered. The official time clock is in the reception area of the Division of Purchases.

### **RESPONSE CONTENTS**

Responses shall include the following:

1. One completed and signed four-page R.I.V.I.P generated bidder certification cover sheet (included in the original technical proposal only) downloaded from the RI Division of Purchases Internet home page at [www.purchasing.ri.gov](http://www.purchasing.ri.gov).
2. One completed and signed W-9 (included in the original technical proposal only) downloaded from the RI Division of Purchases Internet home page at [www.purchasing.ri.gov](http://www.purchasing.ri.gov).
3. **A separate Technical Proposal** describing the qualifications and background of the applicant and experience with and for similar projects, and all information described earlier in this solicitation. As appropriate, resumes of key staff that will provide services covered by this request.
4. **A separate, signed and sealed Cost Proposal** using Appendix VII: Budget Form proposed to complete all of the requirements of this project.
5. In addition to the multiple hard copies of proposals required, Respondents are requested to provide their proposal in **electronic format (CD-ROM, disc, or flash drive)**. Microsoft Word / Excel OR PDF format is preferable. Only 1 electronic copy is requested and it should be placed in the proposal marked “original”.

### **CONCLUDING STATEMENTS**

Notwithstanding the above, the State reserves the right not to award this contract or to award on the basis of cost alone, to accept or reject any or all proposals, and to award in its best interest.

Proposals found to be technically or substantially non-responsive at any point in the evaluation process will be rejected and not considered further.

The State may, at its sole option, elect to require presentation(s) by offerors clearly in consideration for award.

The State's General Conditions of Purchase contain the specific contract terms, stipulations and affirmations to be utilized for the contract awarded to the RFP. The State's General Conditions of Purchases/General Terms and Conditions can be found at the following URL:

<https://www.purchasing.ri.gov/RIVIP/publicdocuments/ATTA.pdf>

## APPENDIX 1

### Resources

#### DEFINITION OF PRIMARY PREVENTION

Block Grant 20% set aside is for a broad array of Primary Prevention strategies directed at individuals not yet identified to be in need of treatment. Comprehensive primary prevention programs should include activities and services provided in a variety of settings for both the general population and targeted sub-groups who are at higher risk for substance abuse.

Primary Prevention refers to a proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles. Primary prevention includes interventions occurring prior to the initial onset of a substance use disorder through reduction or control of causative factors to substance abuse, including the reduction of risk factors contributing to substance use. Services are delivered through six defined federal strategies to three classifications of population as identified by the Institute of Medicine.

#### Incorporating SAMHSA Strategic Initiative(s)

SAMHSA's 2014-2018 Prevention goals include:

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

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

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

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

**IOM Model** refers to the classification system developed by the **Institute of Medicine** that divides the continuum of care into three categories: prevention, treatment and maintenance. The IOM system further classifies prevention interventions according to the level of risk within the populations they target. The IOM model classifies prevention interventions as **universal, selective and indicated**.

**Universal Prevention Intervention** refers to prevention interventions directed to a general population not identified on the basis of risk factors, but for whom prevention activity could reduce the likelihood of developing a problem or disorder. The category of universal prevention intervention is further broken down into direct and indirect interventions. Direct interventions target specific subpopulations; indirect interventions target populations as a whole such as for an entire community.

**Selective Prevention Intervention** refers to prevention interventions directed to subgroups of a population who have a higher-than-average risk for developing a problem or disorder by virtue of their membership in the subgroup. Selective interventions target

the entire subgroup regardless of the level of risk of any individual within the group.

**Indicated Prevention Intervention** refers to preventive interventions directed to specific individuals with known, identified risk factors that place them at higher than average risk for developing a problem or disorder. Such individuals may be experiencing early signs of substance abuse or other related problems but do not meet DSM-V criteria for addiction <http://www.ncbi.nlm.nih.gov/books/NBK32789/>

**Certified Prevention Specialist** refers to individuals who have met the training and professional experience requirements to become a Certified Prevention Specialist according to criteria established by the Rhode Island Board for Certification of Chemical Dependency Professionals, consistent with the International Certification & Reciprocity Consortium/Alcohol and Other Drug Abuse standards.  
[www.ricertboard.org](http://www.ricertboard.org)

**Evidence-based Prevention** refers to a process in which experts use commonly agreed-upon criteria for rating research interventions and come to a consensus that evaluation research findings are credible and can be substantiated. From this process, a set of effective principles, strategies, and model programs can be derived to guide prevention efforts.

In the health care field, evidence-based practice (or practices), also called EBP or EBPs, generally refers to approaches to prevention or treatment that are validated by some form of documented scientific evidence. What counts as “evidence” varies. Evidence often is defined as findings established through scientific research such as controlled clinical studies, but other methods of establishing evidence are considered valid as well. Evidence-based practice stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.

**Effective Prevention Program** refers to an intervention that builds upon established theory, comprises elements and activities grounded in that theory, demonstrates practical utility for the prevention field, has been well implemented and well evaluated, and has produced a consistent pattern of positive outcomes.

**National Registry of Evidence-based Programs and Practices (NREPP)** refers to a United States Department of Health and Human Services/Substance Abuse Mental Health Services Administration (SAMHSA) sponsored review process that identifies and scores evidence-based programs.  
[http://nrepp.samhsa.gov/01\\_landing.aspx](http://nrepp.samhsa.gov/01_landing.aspx)

**Environmental Strategy** refers to activities that establish or change prevalence of the abuse of alcohol, tobacco, and other drugs within the general population. This strategy is divided into four subcategories which target the following variables: rules and regulations of social institutions and the degree to which they are enforced and supported; the norms of the community in which the individual resides; mass media messages which both encourage and discourage **ATOD** use; and the accessibility/availability of ATOD within the community.

## **Strategic Prevention Framework**

The Strategic Prevention Framework (SPF) is based on the following key principles: it follows the public health approach, it is focused on outcomes-based prevention, it widens the scope of prevention to population-level prevention rather than program focused prevention, and it follows a strategic planning process using epidemiological data throughout the process to drive decision making.

The basic five steps of the SPF process include: assessment, capacity, planning, implementation, and evaluation.

**Assessment** profiles population needs, resources, and the readiness to address needs and gaps;

**Capacity** relates to mobilizing and/or building the capacity to address identified needs;

**Planning** includes developing a comprehensive strategic plan;

**Implementation** includes implementing evidence-based prevention programs and activities consistent with the comprehensive strategic plan;

**Evaluation** includes monitoring, evaluating, sustaining and improving or replacing implemented programs and activities.

**Cultural competence** and the capacity of communities to continually apply the SPF process over time to reduce drug-related problems (**Sustainability**) must be considered during all stages of the process.



Other Resources:

[www.preventionplatform.samhsa.gov](http://www.preventionplatform.samhsa.gov)

[www.colorado.edu/cspv/blueprints](http://www.colorado.edu/cspv/blueprints)

U.S. Department of Education's list of Exemplary and Promising Programs

## APPENDIX II

### Performance Measures

#### *Performance Construct: RISS Participation*

- 2018 – 80% of the Districts within the Region participate
- 2020 – 80% of the schools within each district in the Region participate
- 2022 – 80% of grades 7-10 in the municipalities participate
- At time of award a measurable decrease in use of priority substance as demonstrated by the RISS will be negotiated as a performance measure and increase in perception of risk or harm of targeted substance or substances

#### *Representation and Engagement of Six Core Sectors*

- 2018 (Year 2) – 100% representation of the six Core Sectors at the municipal level
- 2019-2020 (Year 2-3) – Expansion of the Sector sub-populations, disciplines or stakeholders at regional level (e.g., different disciplines or stakeholders within the core sectors such as public safety with representation by police, EMTs/firefighters, probation/parole, court liaisons, child protective services) – target at least 3
- 2020-2021 (Year 3-4) - Expansion of the Sector sub-populations, disciplines or stakeholders at MUNICIPAL level (e.g., different disciplines or stakeholders within the core sectors such as public safety with representation by police, EMTs/firefighters, probation/parole, court liaisons, child protective services) – target at least 2 different stakeholder groups

### Deliverables

#### *Expansion of Focus to Include Mental Health Promotion and Wellness (via targeting shared risk and protective factors for substance abuse and mental health))*

- 2019-2020 (Year 2-3) Each region will have at least 1 evidence based program targeted to early and middle childhood focused on social and emotional competencies and/or conflict resolution.
- 2020-2021 (Year 3-4) Each municipality will demonstrate engagement with at least 1 partner who is actively engaged in mental health promotion

#### *Evidence Based Strategies*

2018-2019 – Each municipality will demonstrate implementation by a partner among the Core Sectors represented of 1 individually focused evidence based practice and 1 environmental change strategy

#### *Non-RISS Data Collection*

2018-2019 – each region will have a plan for qualitative data collection for non-adolescent populations

2019 – 2022 – each municipality will conduct the Alcohol Purchase Survey

2018 – 2022 – each municipality will conduct the Synar Survey

**APPENDIX III**

**State of Rhode Island**



**Final  
Strategic Plan for  
Substance Abuse Prevention  
2016-2019**

## **SECTION 1 - INTRODUCTION**

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

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

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

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

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

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

- Assess prevention needs based on epidemiological data
- Build prevention capacity
- Develop a strategic plan
- Implement effective community prevention programs, policies and practices, and
- Monitor, evaluate and document outcomes

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

## **SECTION 2- RHODE ISLAND PREVENTION INFRASTRUCTURE OVERVIEW**

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

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

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

**Rhode Island Prevention Resource Center (RIPRC)** - The RIPRC is a centralized training and technical assistance (TTA) resource for Rhode Island substance abuse prevention providers designed to develop, expand and improve the prevention workforce.

The RIPRC fosters state and local collaboration to prevent substance abuse and other risk-taking behaviors in Rhode Island.

**Rhode Island State Epidemiology Outcomes Workgroup (SEOW)** - The primary mission of the SEOW is to guide in institutionalized data-driven planning and decision making relevant to substance use/abuse and mental illness across Rhode Island. As such, the SEOW operates within the outcomes-based prevention framework, aiming to integrate prevalence and incidence data with risk and protective factors data into its decision-making process and policy-making at the state and community level.

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

**The Rhode Island Certification Board** - The RI Certification Board defines a baseline standard for all credentials offered. Providers are given recognition for meeting specific predetermined criteria in behavioral health services. The RI Certification Board has been a participating member in the International Certification & Reciprocity Consortium (IC&RC) since 1988. (IC&RC sets international standards for professional competencies in behavioral health and develops and maintains written examinations for each reciprocal credential offered.)

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

**The Substance Use and Mental Health Leadership Council of RI (SUMHLC)** – SUMHLC is a nonprofit membership organization funded through the treatment set aside within the Substance Abuse Block Grant. SUMHLC represents public and private alcohol and drug treatment, behavioral health, and prevention while promoting a collaborative, coordinated system of comprehensive community based mental health, substance abuse prevention and treatment services which include but are not limited to treatment and recovery focused training opportunities.

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

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

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

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

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

- Not all priorities or recommendations from the 2015 State Epi Profile are changeable within the time frame addressed with this current prevention strategic plan
- Some priorities are not changeable with primary prevention strategies
- Evidence based or evidence informed interventions fundable with the primary prevention set aside of the Substance Abuse Block Grant may not exist to address the priority

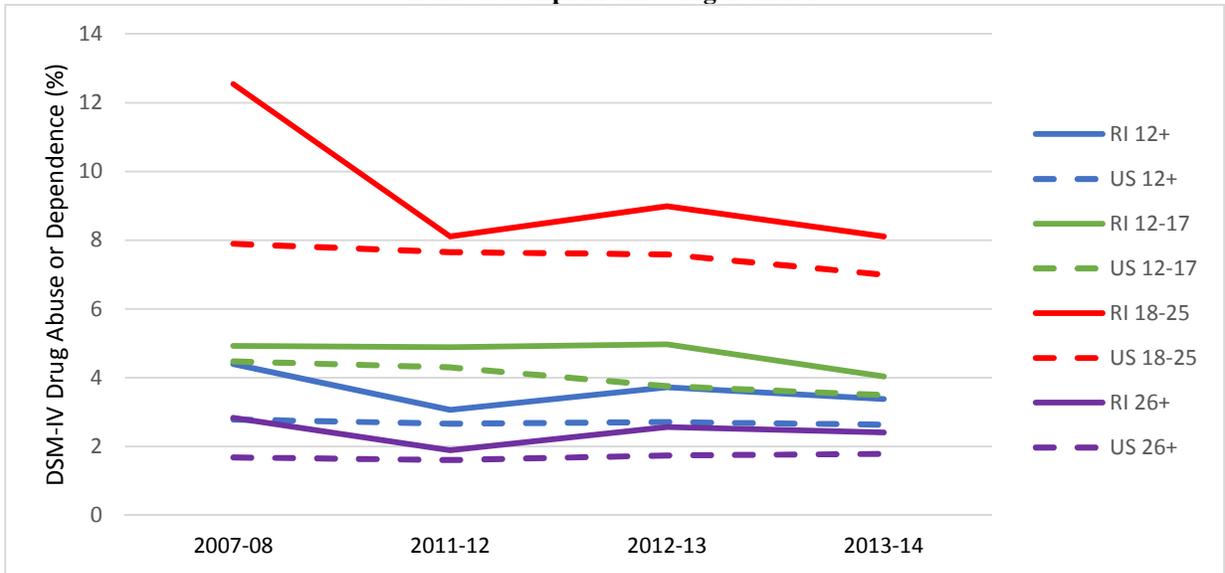
Please consult the full 2015 State Epidemiological Profile for additional analysis and information that provides the justification for the priorities noted in this plan. Time trend charts have been provided within body of this plan. The link to the Profile is available at [www.riprc.org](http://www.riprc.org).

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

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

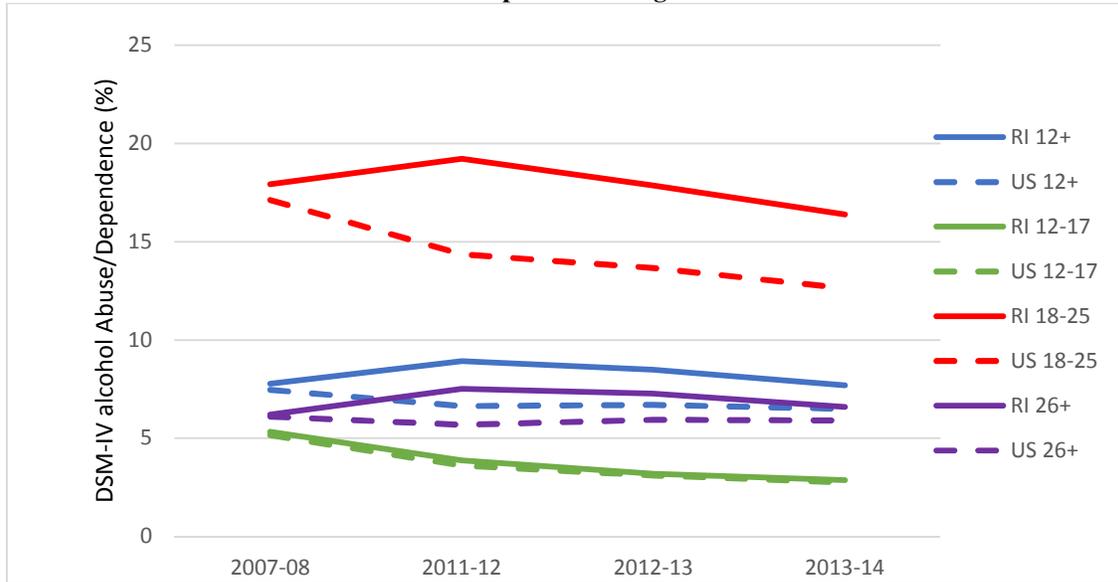
- A. DSM-IV diagnosis of illicit drug dependence or abuse
- B. DSM-IV diagnoses of alcohol dependence or abuse
- C. Drug overdose, especially those attributed to opioids and prescription drugs
- D. Suicide attempts among adolescents

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



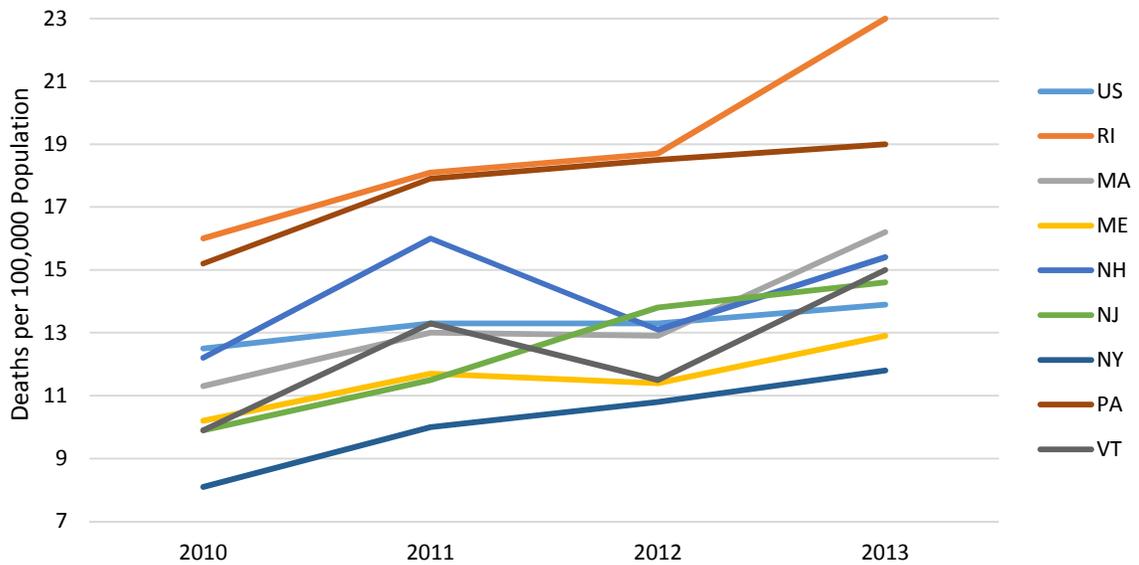
Source: National Survey on Drug Use and Health (NSDUH).

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



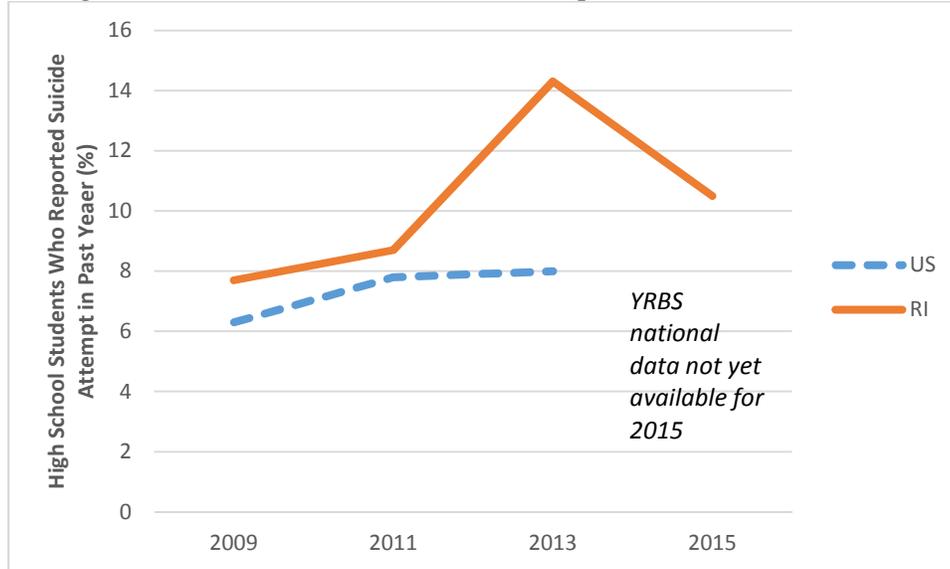
Source: National Survey on Drug Use and Health (NSDUH).

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



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

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



Source: Youth Risk Behavior Survey, Centers for Disease Control

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

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

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

The following priority consumption patterns will be targets for primary prevention strategies based on their severity as compared to US rates, troubling trends or to maintain primary prevention efforts that have resulted in reductions in use or favorable trends in the right direction.

BHDDH would seek a reduction on the magnitude of 3-4 % with consumption rates that exceed national averages so that RI rates are at or below national averages among those populations for which there is valid and reliable survey instruments that can be used at the sub-state level. The time frame in which measurable change would be expected is five to seven years, which extends beyond the time period covered by the plan. Where Rhode Island consumption patterns are at or below national averages, BHDDH will continue to implement efforts to maintain below national averages. The priority consumption patterns include:

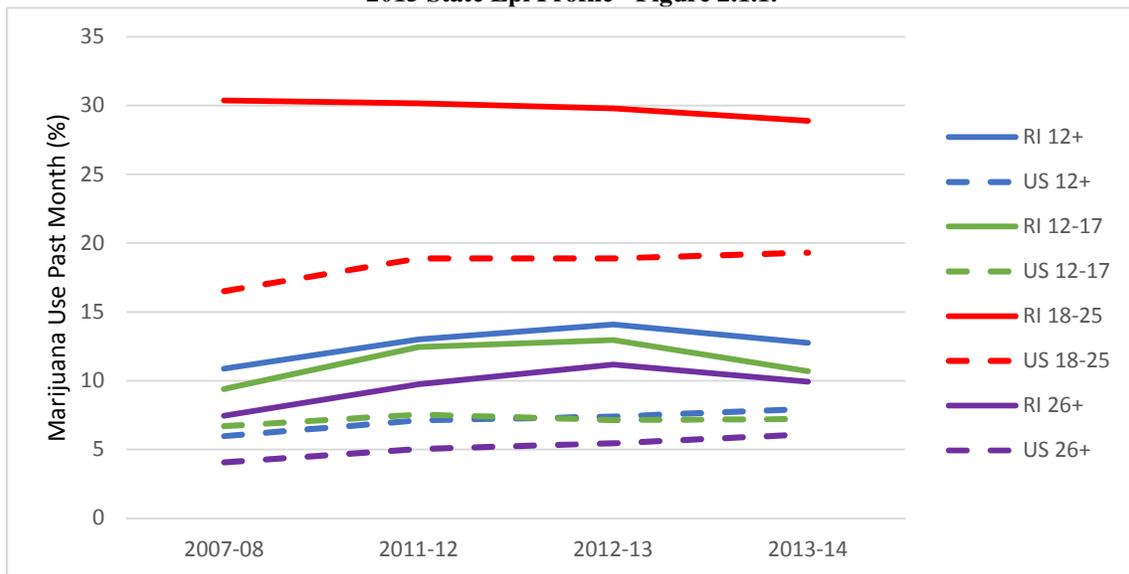
- A. Marijuana use by adolescents ages 12-17
- B. Use of illicit drugs other than marijuana 12-25
- C. Underage drinking 12-20
- D. Youth use of tobacco or tobacco related products especially use of electronic nicotine delivery systems (ENDS).

<sup>1</sup> Please note that the 2013 percentages reported in the chart above are believed to be an anomaly based on the RI Department of Health’s review of other data for the same time frame

*Marijuana Use by Adolescents*

Regarding findings related to youth marijuana use: relevant tables from the 2015 State Epidemiological Profile include Tables 2.1.1 and 2.2.0 featuring trend data from 2007-2008 to 2013-2014 from the Substance Abuse Mental Health Services Administration’s National Survey on Drug Use and Health, and Tables 2.1.9 and 2.2.3 from the Centers for Disease Control’s Youth Risk Behavior Survey which includes trend data from 2001-2015. Major findings from the NSDUH are that RI has exceeded the national average for use across the life span since 2007-2008 by substantial margin of almost double the national rates in some age categories. These rates had significant decreases from 2012-2013 to 2013-2014 but the rates were still considerably higher than the national average.

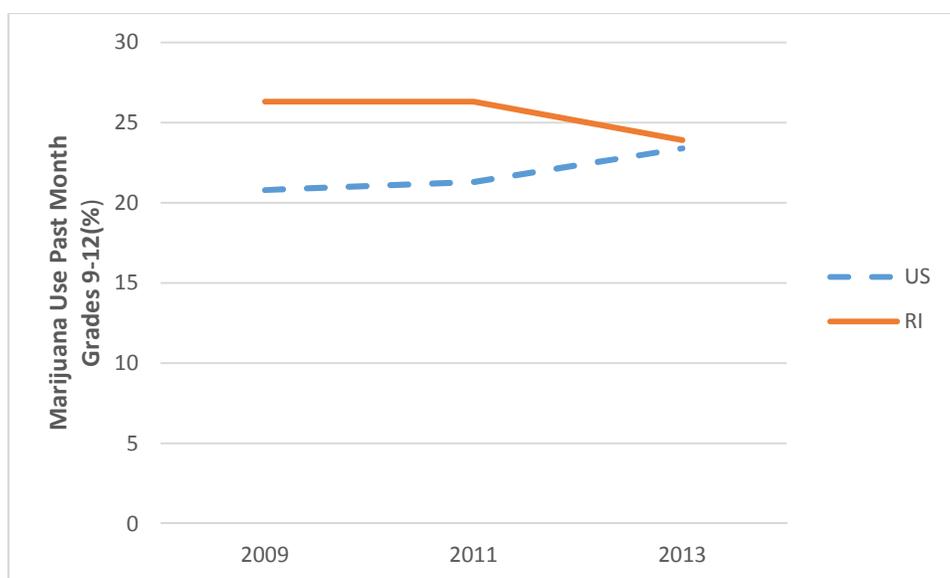
**RI vs. US Marijuana Use Past Month by Age Group, 2007-2014**  
**2015 State Epi Profile - Figure 2.1.1.**



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

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

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



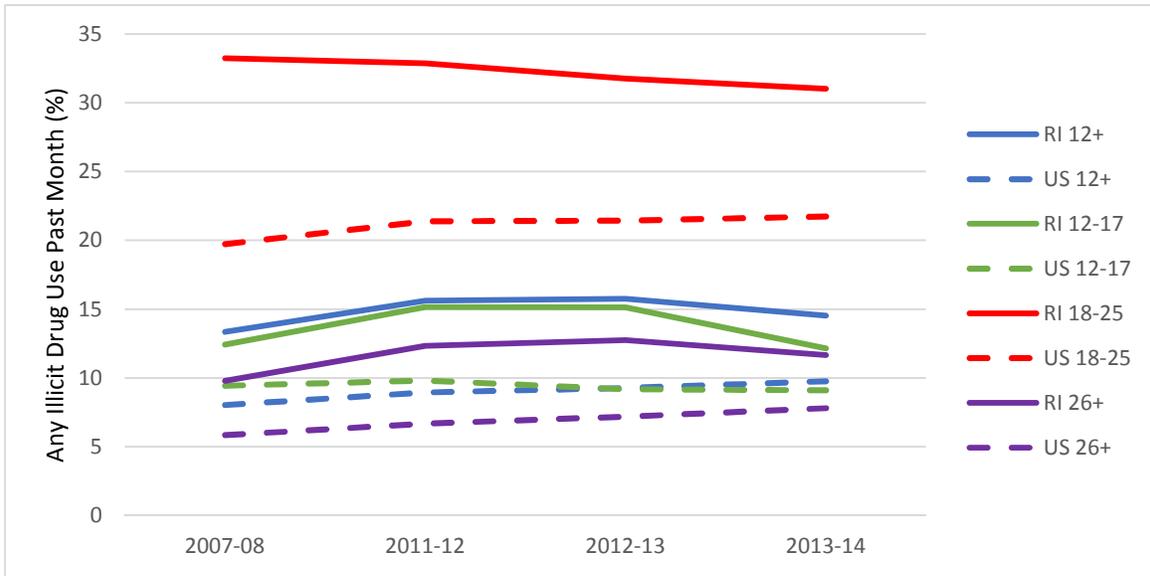
Source: Youth Risk Behavior Survey, Centers for Disease Control

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

*Illicit Drug Use*

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

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

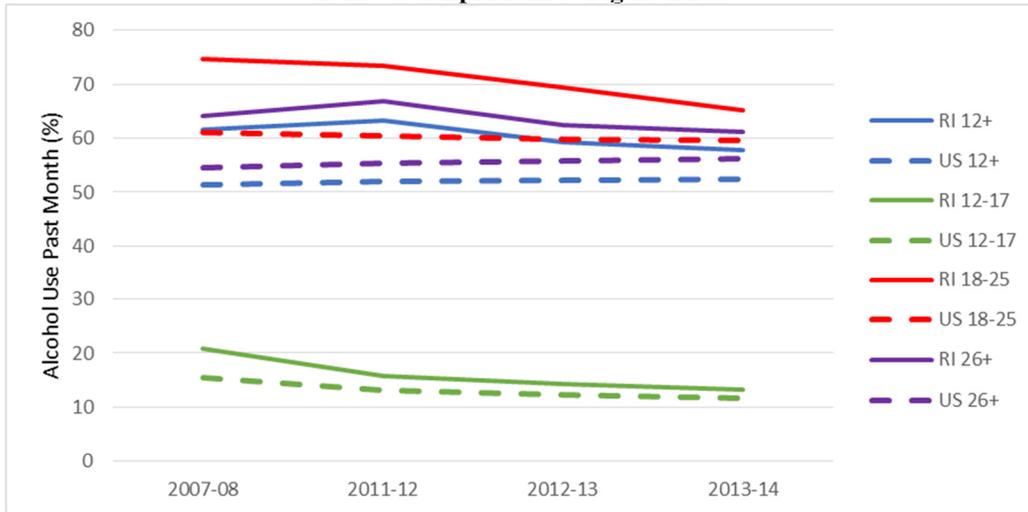


Source: National Survey on Drug Use and Health (NSDUH)

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

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

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

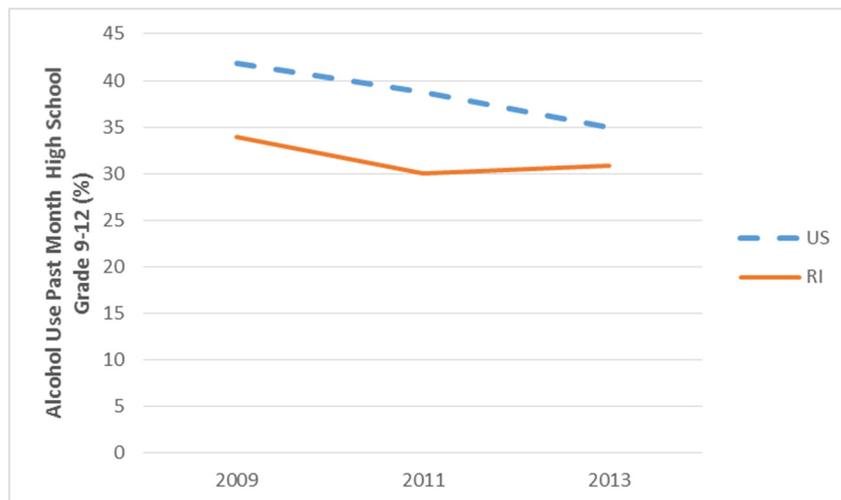


Source: National Survey on Drug Use and Health (NSDUH)

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

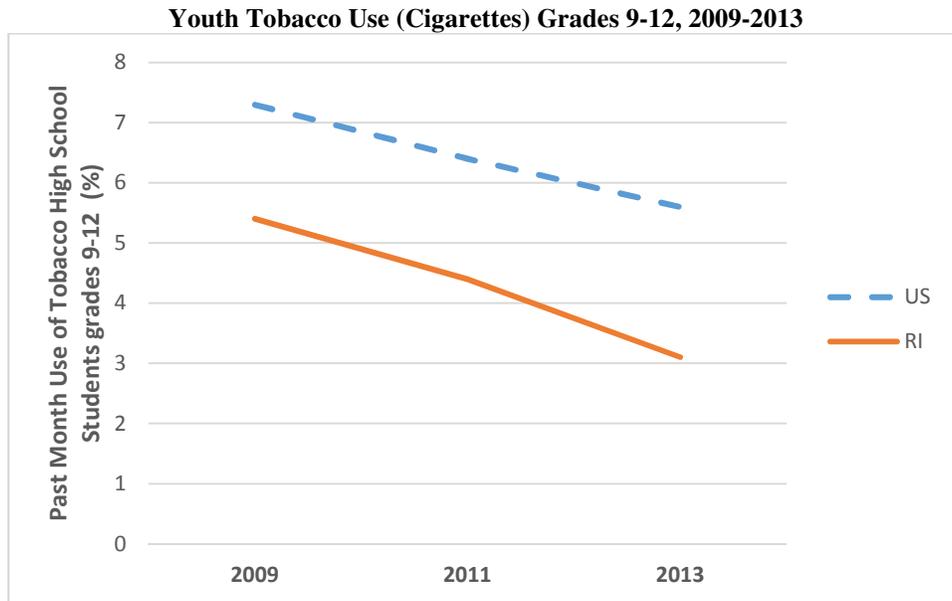
### Youth Alcohol Use Grades 9-12, 2009-2013

Source: Youth Risk Behavior Survey, Centers for Disease Control



*Youth Tobacco Use*

Even though the national trends for smoking also declined in this time period, reduction in these consumption trends was greater for Rhode Island. The 2015 Youth Risk Behavior Survey reported 19.3 of high school youth (grades 9-12) reported using electronic vapor products (electronic nicotine delivery systems). This constitutes an emerging need.



Source: Youth Risk Behavior Survey, Centers for Disease Control

## C. RISK & PROTECTIVE FACTORS

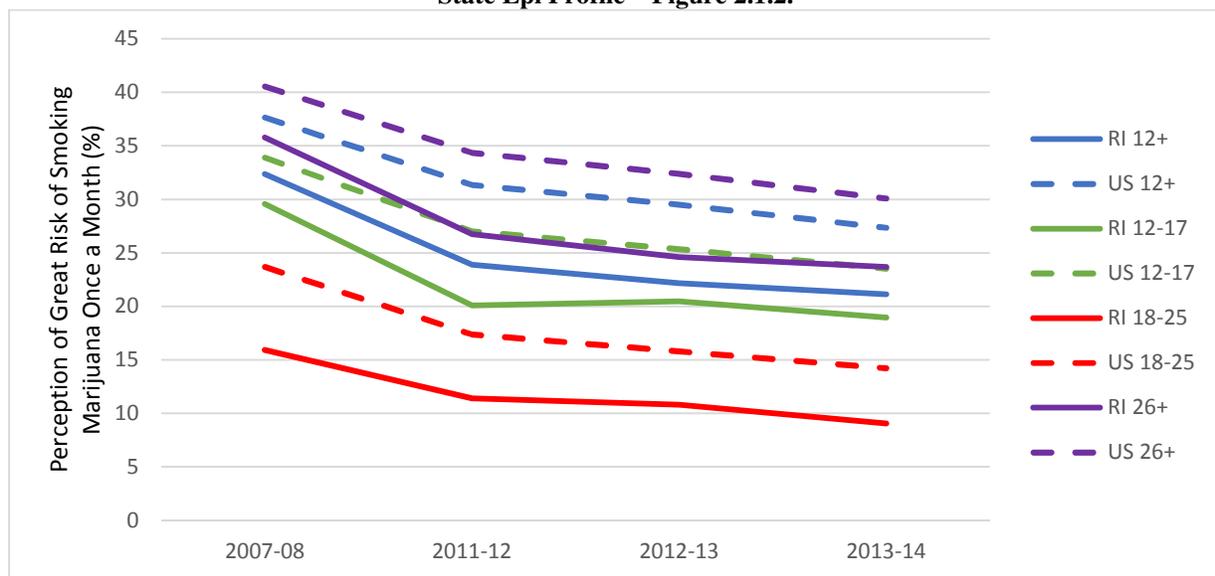
State or community level indicators related to behavioral health risk or protective factors are not as readily available as other indicators of consumption or consequences. The priority risk or protective factors are those that appear in research studies related to prevention of substance abuse. Currently,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

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

### 1. Perception of risk or harm

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

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



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

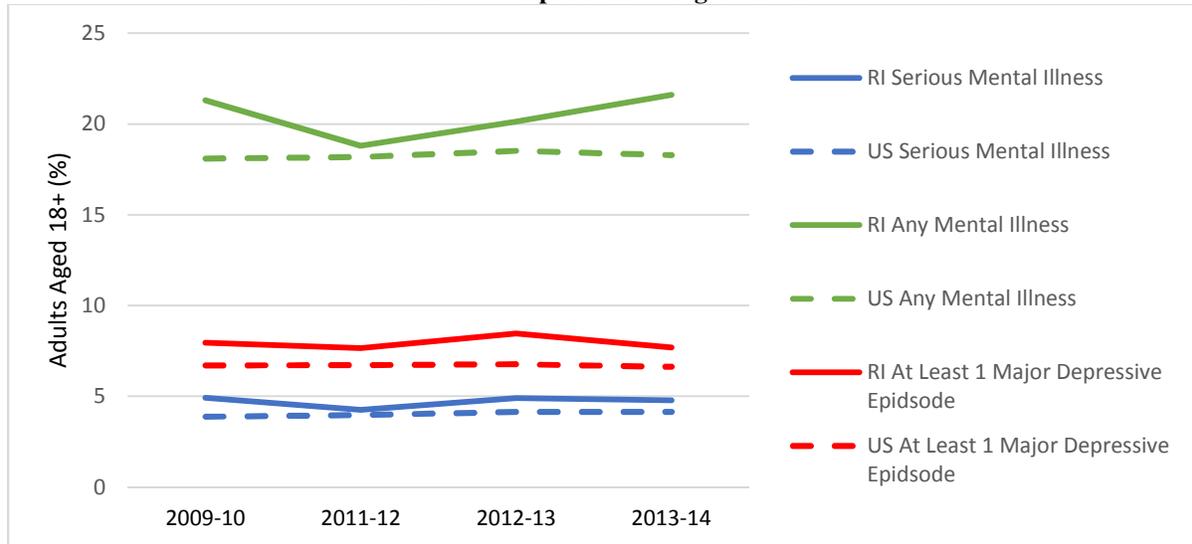
### 2. Access and Availability of Substances With Age Based or Other Conditional Use Restrictions

Use of alcohol and tobacco is restricted to adults, which is defined as 21 for alcohol and 18 for tobacco. Currently, marijuana possession and use is illegal in Rhode Island. In the case of

medical marijuana, there may be some circumstances in which an underage individual has a medical marijuana card permitting possession or use of marijuana for medical purposes. Other related risk or protective factors are derived from research literature or other reputable sources and can be targeted with funds based on departmental approval.

## D. MENTAL HEALTH

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



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

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

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

## **SECTION 4 - ALIGNMENT WITH SAMSHA'S STRATEGIC INITIATIVES**

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

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

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

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

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

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

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

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

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

## **SECTION 5 - STRATEGIC PLANNING GOALS AND OBJECTIVES**

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

### **A. SYSTEM-LEVEL INFRASTRUCTURE DEVELOPMENT:**

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

**Objective I:** By January 31, 2017, BHDDH will implement a new prevention service delivery model.

(Please note: the RFP for prevention providers is currently under development. BHDDH will update this plan with specific objectives and measures once the new prevention delivery system plan can be made public.)

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

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

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

**Objective II:** Maintain a consistent meeting schedule of groups addressing behavioral health issues. Each meeting will specifically identify opportunities to address the following: 1) to increase communication across the sectors; 2) to identify increased opportunities for collaboration across sectors; 3) to ensure promotion of existing prevention services and initiatives and; 4) to document the integration of prevention and mental health promotion across behavioral health provider systems.

Meetings will include and meet as follows:

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

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

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

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

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

- 1) BHDDH Prevention and Planning Unit\*
- 2) Department of Health (HEALTH) and/or Community Violence Prevention and/or Suicide Prevention \*
- 3) RI Substance Abuse Prevention Act (RISAPA) \*
- 4) Mental Healthcare
- 6) Certified Prevention Specialist\*

- 7) Student Assistance Program \*
- 8) State Epi Outcomes Workgroup (SEOW) \*
- 9) Department of Youth and Family Services Prevention Specialist/Family Community Care Partnership Representative (s)
- 10) Military Prevention
- 11) School-based Healthcare
- 12) Community/School Health Educator (s)
- 13) Physical Healthcare Provider (s)
- 14) Parent Organizations
- 15) Law Enforcement
- 16) Tobacco Control Prevention Specialist (s)
- 17) Recovery and Treatment
- 18) Developmental Disabilities
- 19) RI Department of Education
- 20) Youth Organizations
- 21) Mental Health Promotion
- 22) Evidence-based Practice Workgroup

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

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

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

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

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

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

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

## **B. WORKFORCE DEVELOPMENT AND SUSTAINABILITY:**

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

**Objective I:** By January 1, 2017, establish a modified prevention service delivery system which includes a multi-tiered classification of prevention providers. The classification will be designed, in consultation with the RI Certification Board, to acknowledge and document the varying levels of content expertise within the prevention service delivery system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## **SECTION 6 - SUMMARY and CONCLUSION**

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

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

## APPENDIX IV

**Rhode Island Population - 1,052,567 people** (based off of 2010 Census Data)

\$1.42 Per Person Calculation Based off of \$1.5 Million/RI Population

**Request: Overall budget for the region administration (personnel up to max of 60k inclusive of salary and fringe (fringe can be in kind or matching) indirect <10% based on cost of running regional office) + budget for municipal allocations**

**#1 Southern Providence County – 187,345 people \$266,029.90**

**10% Administration - \$26,602.99**

Cranston – 80,387 people

Foster – 4,606 people

North Providence – 32,078 people

Scituate – 10,329 people

Glocester – 9,746 people

Johnston – 28,769 people

Smithfield – 21,430 people

**#2 Northern Providence County/ Blackstone Valley – 214,243 people \$304,225.06**

**10% Administration - \$30,422.50**

Burrillville – 15,955 people

Central Falls - 19,376 people

Cumberland – 33,506 people

Lincoln – 21,105 people

North Smithfield – 11,967 people

Pawtucket – 71,148 people

Woonsocket - 41,186 people

**#3 Providence – 178,042 people \$252,819.64**

**10% Administration - \$25,281.96**

Providence – 178,042 people

**#4 Kent County – 172,611 people \$245,107.62**

**10% Administration - \$24,510.76**

Coventry – 35,014 people

Exeter – 6,425 people

West Greenwich – 6,135 people

East Greenwich – 13,146 people

West Warwick – 29,191 people

Warwick – 82,672 people

**#5 East Bay – 96,912 people \$137,615.04**

**10% Administration - \$13,761.50**

East Providence - 47,037 people

Barrington – 16,310 people

Warren – 10,611 people

Bristol – 22,954 people

**#6 Newport County – 82,950 people \$117,789**

**10% Administration - \$11,778.90**

Jamestown – 5,405 people

Little Compton – 3,492 people

Middletown – 16,150 people

Newport - 24,672 people

Portsmouth – 17,389 people

Tiverton – 15,780 people

**#7 South County – 120,554 people \$171,186.68**

**10% Administration - \$17,118.66**

Charlestown – 7,827 people

Hopkinton – 8,188 people

Narragansett – 15,868 people

New Shoreham – 1,051 people

North Kingstown – 26,486 people

Richmond – 7,708 people

South Kingstown – 30,639 people

Westerly – 22,787 people

## APPENDIX V

### **Youth Access to Tobacco Products**

Section 1926 of the federal Alcohol, Drug Abuse and Mental Health Administration Reorganization Act of 1992 (PL 102-321) known as the “Synar Amendment requires all states to have in effect a law prohibiting the sale or distribution of tobacco products to individuals under the age of eighteen (18) and to enforce that law in a manner which can reasonably be expected to reduce the extent to which individuals under the age of eighteen have access to such products. State compliance with Synar Amendment regulations is a condition for receipt of the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. In order to comply with Synar Amendment regulations, the state must at a minimum:

- Conduct an annual survey of a scientifically-sound random sample of retail tobacco outlets statewide to determine retailer compliance with the state’s youth access to tobacco law;
- Maintain a statewide retailer violation rate under 20%;
- Conduct and report on on-going enforcement of the state’s youth access to tobacco law
- Every three years, conduct a coverage study to determine the accuracy of the state’s retail tobacco license list;
- Conduct ancillary prevention strategies designed to reduce youth access to tobacco products

The successful applicant will be required to assist the Department in addressing the federal mandate that states conduct ancillary prevention strategies designed to reduce youth access to tobacco products by implementing either Strategy Option A or B at the regional level in order to achieve economies of scale and to increase the impact of the selected strategy in reducing youth access to tobacco products as measured by the Annual Synar Survey and the YRBS. Selection of the strategy option and subsequent implementation plan must be included in the regional plan.

In addition, as required by the federal Center for Substance Abuse Prevention, the regional Coordinator will be expected to coordinate the conduct of the Synar Coverage Study within their respective region; and all municipal coalitions will be expected to assist BHDDH in conducting the Coverage Study.

### **Option A-Local Policies and Ordinances Related to Point of Sale Purchase Restrictions**

Educating community leaders and advocating for local policies/ordinances related to point of sale (POS) purchase restrictions.

Evidence-based POS restrictions include:

- Local permitting of tobacco outlets
- Ban on the sale of all tobacco products to underage individuals (including ENDS products)
- Ban on the sale of loose cigarettes
- Requirement that all tobacco products and ENDS products be placed behind a counter (no self-service displays)

- Ban on the sale of tobacco-related paraphernalia to minors
- Ban on pricing discounts: e.g., coupon redemption and multi-pack discounts
- Ban on the sale of non-cigarette flavored tobacco and ENDS products

**Please Note:** If one or more coalitions within a region has received grant funding through the Tobacco Control Program at the Health Department, resulting initiatives may be the basis for implementing Option A at the regional level.

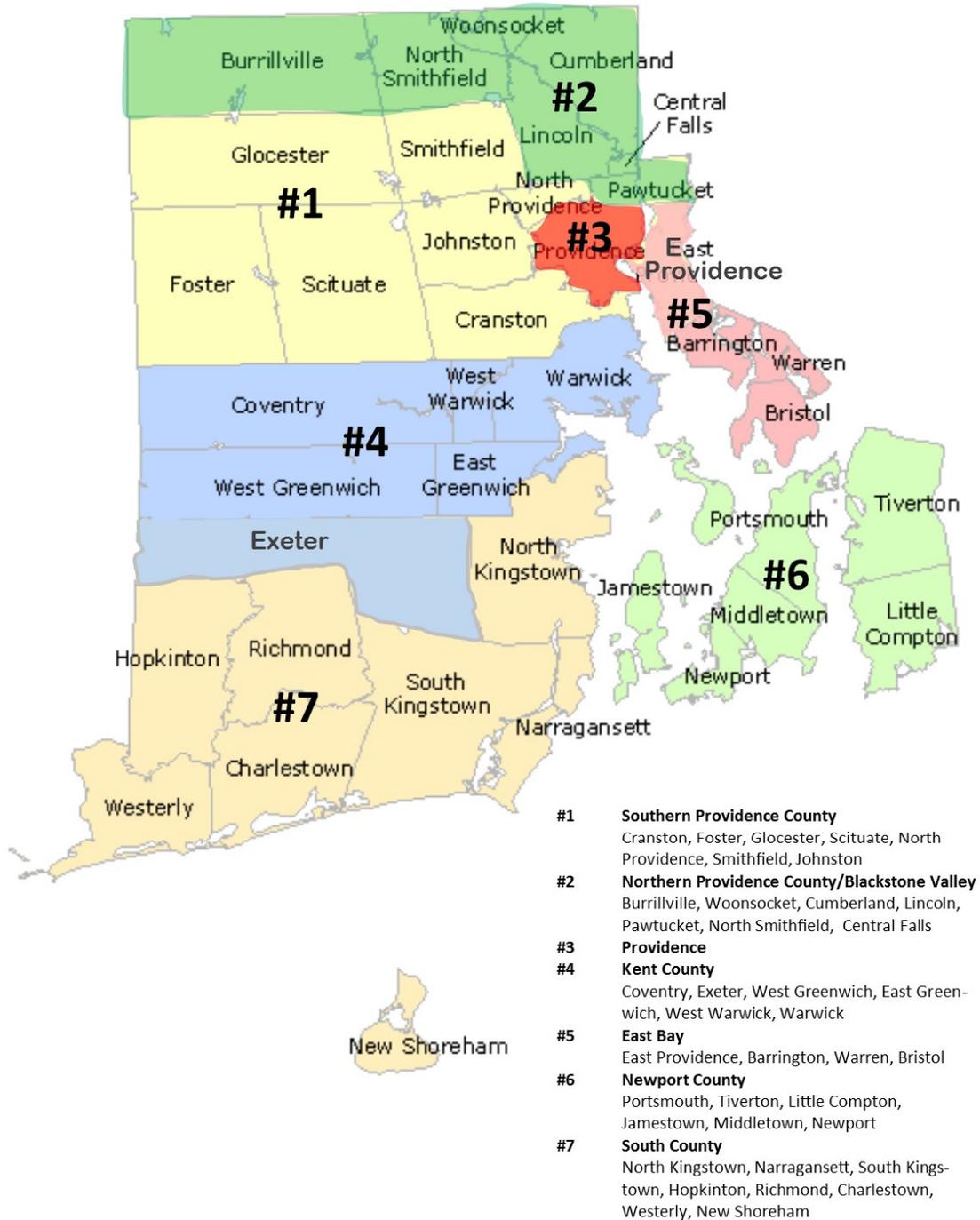
### **Option B-Tobacco Retailer Education**

Educating all retail tobacco licensees within a region on federal and RI law relating to the sale or distribution of tobacco products utilizing standardized resources provided by BHDDH.

While implementation of **Option A or B is required at the regional level**, municipalities within a region are encouraged to consider implementing other prevention strategies designed to reduce youth access to tobacco products including:

- Hosting community events to educate community members about youth access to tobacco products, with a particular focus on emerging tobacco products such as electronic nicotine delivery systems (ENDS) products, hookah and flavored non-cigarette products;
- Conducting a media campaign to publicize the results of the annual Synar Survey and on-going enforcement efforts within the community;
- Conducting a community or school-based event for World No Tobacco Day, Kick Butts Day or the Great American Smokeout (if the event will address youth access to tobacco).

## APPENDIX VI



## APPENDIX VII – BUDGET FORM

Contract Agency: \_\_\_\_\_

Contract Service: \_\_\_\_\_

| Category /Item                             | Proposed Budget | Leveraged Funds | Total Budget                      |
|--|-----------------|-----------------|-----------------------------------|
| [col. 1]                                   | [col. 2]        | [col. 3]        | [col. 4]<br>col 4 = col 2 + col 3 |
| 1) Salaries                                |                 |                 |                                   |
| 2) Fringe Benefit                          |                 |                 |                                   |
| 3) Contractual Services                    |                 |                 |                                   |
| 4) Travel (in state)                       |                 |                 |                                   |
| 5) Conference (out of state)               |                 |                 |                                   |
| 6) Postage/Office Supplies/Expenses        |                 |                 |                                   |
| 7) Telephone/Cable/Internet                |                 |                 |                                   |
| 8) Information System                      |                 |                 |                                   |
| 9) Property Rent                           |                 |                 |                                   |
| 10) Heat & Utilities                       |                 |                 |                                   |
| 11) All Other costs appropriate to program |                 |                 |                                   |
|  |                 |                 |                                   |
|  |                 |                 |                                   |
|  |                 |                 |                                   |
|  |                 |                 |                                   |
| 12) Agency Overhead-Indirect               |                 |                 |                                   |
|  |                 |                 |                                   |
| <b>TOTAL</b>                               | <b>\$0.00</b>   | <b>\$0.00</b>   | <b>\$0.00</b>                     |

| <b>Item # 1<br/>Salary Costs</b> |                |   |                              |               |               |
|----------------------------------|----------------|---|------------------------------|---------------|---------------|
| Position Title                   | # of Positions | Total Annual Salary<br>[contract year earnings] | Salary Chargeable to Program |               |               |
|                                  |                |   | BHDDH                        | Leveraged     | Combined      |
|                                  |                |   |                              |               |               |
|                                  |                |   |                              |               |               |
|                                  |                |   |                              |               |               |
|                                  |                |   |                              |               |               |
|                                  |                |   |                              |               |               |
|                                  |                |   |                              |               |               |
| <b>Total Salaries</b>            |                | N/A   | <b>\$0.00</b>                | <b>\$0.00</b> | <b>\$0.00</b> |

| Item # 2 Fringe Benefits & Other Personnel Costs | Fringe Benefits Chargeable to Program |                 |               |
|--|---------------------------------------|-----------------|---------------|
|  | BHDDH                                 | Leveraged Funds | Combined      |
|  |                                       |                 |               |
|  |                                       |                 |               |
|  |                                       |                 |               |
|  |                                       |                 |               |
|  |                                       |                 |               |
|  |                                       |                 |               |
| <b>Total Fringe Benefits</b>                     | <b>\$0.00</b>                         | <b>\$0.00</b>   | <b>\$0.00</b> |

| Item # 3<br>Consultant Costs<br>(list each contract consultant service) | # of Hours | Hourly Rate | Consultants Chargeable to Program |                 |               |
|---|------------|-------------|-----------------------------------|-----------------|---------------|
|   |            |             | BHDDH                             | Leveraged Funds | Combined      |
|   |            |             |                                   |                 |               |
|   |            |             |                                   |                 |               |
|   |            |             |                                   |                 |               |
|   |            |             |                                   |                 |               |
|   |            |             |                                   |                 |               |
| <b>Total Consultant Costs</b>   |            | N/A         | <b>\$0.00</b>                     | <b>\$0.00</b>   | <b>\$0.00</b> |

