Rules and Regulations for the Certification of Substance Abuse Prevention Organizations

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF MENTAL HEALTH, RETARDATION AND HOSPITALS

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State of Rhode Island
And Providence Plantations

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Department of Mental Health,
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Preface

The Department of MHRH staff, in conjunction with providers in the Rhode Island prevention community, has designed these prevention certification standards with the needs of all Rhode Islanders uppermost in mind; they are intended to be flexible and responsive enough to allow for the continued development and improvement of innovative prevention services. These Standards have been promulgated to ensure that basic requirements for providing highest-quality prevention services to all Rhode Islanders are met; to ensure that organizations providing prevention services promote the health and well-being of all who they serve; and to ensure that providers utilize an ethical code of conduct in accordance with national prevention certification criteria. These Standards are intended to provide a framework for prevention program planning and service delivery.

In order to comply with these standards, all MHRH-funded organizations providing prevention services must ensure that all locations where prevention services are conducted meet safety and Americans with Disabilities Act (ADA) requirements; that prevention staff is adequate in number and properly trained to carry out the goals/objectives of each MHRHfunded prevention program; and that the overall philosophy, objectives and services are responsive to the needs of those served and are consistent with the substance abuse prevention certification standards contained herein.

Statutory Authority for Certification Standards

Authority for these standards is found in Rhode Island General Laws §40.1-1-13.

Applicability

These certification standards apply to all organizations funded by MHRH to provide substance abuse prevention services. All references within these standards are incorporated by reference and have the same force and effect as if promulgated herein.

The Department shall report substantial violations of any and all applicable statutes, rules and regulations to the appropriate state or federal department, agency or authority.

Rhode Island Prevention System Framework

The vision for Rhode Island's prevention system consists of culturally-appropriate evidence-based programs and best practices which are aligned in comprehensive community-based prevention at the municipal level; and are supported by coordinated funding and technical assistance at the State level.

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The risk and protective factor model for prevention developed by Hawkins & Catalano (1992) is the framework within which the Division of Behavioral Healthcare Services plans, implements, monitors, and evaluates all of its prevention efforts. The basis for this model is the identification of underlying conditions, personal and environmental, which contribute to or are associated with a specific problem behavior or set of behaviors, as well as conditions which mitigate the behavior(s). This framework incorporates five spheres of influence referred to as "domains" within which these risk and protective factors operate: individual, peer, family, school, and community/society.

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Risk factors include biological, psychological/behavioral, and social/environmental characteristics such as a family history of substance abuse, depression, or antisocial personality disorders, residence in neighborhoods where substance abuse is tolerated, and access to or ready availability of alcohol and other drugs. Prevention interventions seek to reduce or mitigate these factors.

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Protective factors include positive personal characteristics and circumstances such as family, peer, school and community norms which do not support alcohol, tobacco and other drug use/abuse. Prevention interventions seek to strengthen and sustain these factors.

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Current research has demonstrated that a comprehensive approach is most effective in reducing risk factors and supporting protective factors within a target population. Therefore, the Division promotes the planning and delivery of multiple prevention strategies to multiple target populations, youth and adults, within multiple domains.

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Consistent with this policy, the Division has adopted the Institutes of Medicine (IOM) model for prevention. This model divides the prevention category within the health care continuum of prevention, treatment, and maintenance into three classifications: universal, selective and indicated interventions. These classifications are intended to ensure that the intensity of prevention interventions is consistent with and appropriate for the level of need within the target populations(s).

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The Division also plans, implements, evaluates and funds prevention efforts consistent with the strategy categories developed by the Federal Center for Substance Abuse Prevention (CSAP). These categories include: Information Dissemination, Education, Healthy Alternatives,* Community-Based Process, Environmental, and Early Identification and Referral.

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All of the Division's prevention efforts are designed to promote implementation of interventions which have been shown by research and "best practice" to be effective in preventing substance abuse and related problems, particularly through the development of an outcome-based prevention service delivery system.

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*Please note that as a matter of policy, the Division does not fund stand-alone alternative initiatives.

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Part I Definitions and Monitoring Procedures

Section 1.0: Definitions

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The following terms and definitions are used in the Rhode Island Prevention Certification Standards. They shall have the assigned meanings throughout these certification standards unless a specific context clearly indicates otherwise:

1.1 **Addiction** refers to the process of chronic, compulsive behaviors most often associated with alcohol, tobacco, and other drug abuse, gambling and other compulsive behaviors.

1.2 **Agency** refers to any public or privately constituted organization that provides substance abuse prevention services in the State of Rhode Island.

1.3 **ADA** refers to the Americans with Disabilities Act that requires accessibility of services for handicapped or otherwise disabled persons.

1.4 **Adaptation** refers to a process defining the degree to which a program undergoes change in its implementation to fit the needs of a particular delivery situation. Types of adaptation include additions, deletions, or modifications to content, delivery method, target population, setting, or delivery agent as well as evaluation modifications.

1.5 **Advanced Certified Prevention Specialist** refers to individuals who have met the training and professional experience requirements to become an Advanced 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.

1.6 **Attendee** refers to a person who attends a single prevention service/event.

1.7 **ATOD** refers to alcohol, tobacco, and other drugs.

1.8 **Behavioral Health/Healthcare** refers to the umbrella term that encompasses all mental health and substance abuse-related prevention, assessment and referral, and treatment services.

1.9 **Best Practice,** for prevention, refers to principles of program content and service delivery that reflect the type and implementation of service recommended by research, professional literature, and professional experience.

1.10 **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.

1.11 **Certified Prevention Specialist Supervisor** refers to individuals who have met the training and professional experience requirements to become a Certified Prevention Specialist Supervisor 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.

1.12 **Certified Student Assistance Counselor** refers to individuals who have met the training and professional experience requirements to become a Certified Student Assistance Counselor 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.

1.13 **CSAP** refers to the **Center for Substance Abuse Prevention** a Center of the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA).

1.14 **Coalition** refers to a formal arrangement for collaboration between groups or sectors of a community, in which each group retains its own identity, but all agree to work together toward a common goal of a safe, healthy and drug-free community; for purposes of these standards, Rhode Island Substance Abuse Prevention Task Forces are considered coalitions.

1.15 **Collaboration** refers to a process of participation through which people, groups and organizations come together in a mutually beneficial and well-defined relationship to work toward results they are more likely to achieve together than alone.

1.16 **Core Measures** refers to a compendium of data collection instruments that measure those underlying conditions – risks, assets, attitudes, and behaviors of different populations – related to the prevention and/or reduction of ATOD use.

1.17 **Cultural Competence** refers to a set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. A culturally-competent intervention is one that demonstrates sensitivity to and understanding of cultural differences in intervention design, implementation, and evaluation.

1.18 **Department** refers to the Rhode Island Department of Mental Health, Retardation, and Hospitals ("MHRH") ("Department").

1.19 **Director** refers to the Director of the Department of Mental Health, Retardation and Hospitals.

1.20 **Division** refers to the Rhode Island Department of Mental Health, Retardation, and Hospitals, Division of Behavioral Healthcare Services, the unit within the Department that is responsible for mental health and substance abuse prevention, intervention and treatment services.

1.21 **Domain** refers to a sphere of activity or affiliation within which people live, work, and socialize; domains are commonly divided into life activity categories including: individual, peer, family, school, community, and society.

1.22 **DSM** refers to the Diagnostic and Statistical Manual of Mental Disorders, most current edition.

1.23 **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.

1.24 **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.

1.25 **Evidence-based Prevention** refers to a process in which experts use commonly agreedupon 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.

1.26 **Fidelity** refers to the extent to which the delivery of a prevention program conforms to the curriculum, protocol or guidelines for implementing the program.

1.27 **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-IV criteria for addiction.

1.28 **Individual-Focused Strategy** refers to prevention interventions focused on reducing risk factors and enhancing protective factors that influence an individual's decision to use **ATOD**. Risk and protective factors to be addressed in conducting individual-focused strategies include, but are not limited to: an individual's knowledge of and attitudes toward the consequences of ATOD use; decision-making capabilities; peer resistance skills; academic performance; and family history.

1.29 **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**.

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1.30 **Intermediate Objective** refers to description of a measurable, quantitative desired change in a risk or protective factor during a specified time period, which, if achieved, can reasonably be expected to result in a desired change in a problem behavior for a target population.

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1.31 **Logic Model** refers to a graphic description of the components of a theory or program/initiative that shows the plausible linkages between the components.

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1.32 **MIS** refers to the **Division's** management information system designed to collect prevention program service data.

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1.33 **Model Prevention Programs** and strategies have credible, substantiated findings that have been subjected to critical review and been replicated in a variety of settings. CSAP Model Program developers have agreed to provide quality materials and training and technical assistance to practitioners who wish to adopt their programs.

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1.34 **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.

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1.35 **NIDA** refers to the National Institute on Drug Abuse, a part of the National Institutes of Health, Department of Health and Human Services.

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1.36 **Organization** refers to those public or private entities engaged in community services or community development that may directly or indirectly affect the nature and extent of a community's response to alcohol, tobacco, and other drug abuse and related problems and concerns. For the purposes of these standards, organizations include agencies and community coalitions/task forces.

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1.37 **Orientation** refers to a process to provide initial training and information to new staff and to assess their competence related to their job responsibilities and the organization's mission, vision and values.

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1.38 **Outcome Objective** refers to a description of a long-range measurable, quantitative desired change in an identified problem behavior. It is specific and time-limited; it identifies a target population, and it describes the level of change expected in the problem behavior.

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1.39 **Participant** is an individual enrolled in a recurring prevention service.

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1.40 **Prevention (CSAP working definition)** refers to an ongoing process that promotes constructive lifestyles and norms that discourage **ATOD** use, as well as the development of social and physical environments that facilitate drug-free lifestyles. Prevention is achieved through the application of multiple strategies in multiple settings, targeted toward a common goal.

1.41 **Prevention Information Center** refers to an entity or organization that provides current, research-based prevention ATOD information and resource materials; prevention information resource centers may also provide training and technical assistance services.

1.42 **Prevention Services** for the purposes of these standards, refers to prevention services funded by the Department of MHRH.

1.43 **Prevention Training** refers to the provision of structured instruction to develop professional proficiency in prevention program design, development, implementation and evaluation.

1.44 **Primary Prevention Strategies** are the six defined methods and approaches to meeting Substance Abuse Prevention and Treatment Block Grant requirements for primary prevention funding. Strategies include: Information Dissemination, Education, Alternatives, Community-Based Process, Problem Identification and Referral, and Environmental (including Enforcement and Policy strategies). (Definitions for each Strategy are contained within these Standards.)

1.45 **Principles of Effectiveness** under PL 107-110, Title IV of the No Child Left Behind Act, refers to elements that effective interventions have in common, and that have been identified through the careful evaluation of programs. Local prevention programs and activities funded with US Department of Education, Safe and Drug-Free Schools and Communities funds are required to meet the Principles of Effectiveness.

1.46 **Problem Statement** describes documented, quantitative evidence of the extent of a problem behavior within a specified target population.

1.47 **Program** refers to a structured intervention (including environmental initiatives) designed to change social, physical, fiscal, or policy considerations within a definable geographic area or for a defined population.

1.48 **Program Service Plan** refers to written documentation of the intended programs, services, and/or activities that an agency/ organization/coalition intends to carry out during a specified period of time.

1.49 **Promising Prevention Programs** refers to programs that provide useful, scientifically defensible information about what works in prevention but do not yet have sufficient scientific support to meet standards set for CSAP Model or Effective Programs.

1.50 **Protective Factor** refers to an influence that inhibits, reduces or buffers the probability of **ATOD** use/abuse or a transition to a higher level of involvement with **ATOD**.

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1.51 **Recurring Prevention Service** is a planned and recurring sequence of multiple, structured activities intended to inform, educate, impart skills, deliver services, shape/influence policies, and/or provide appropriate referrals for other services, through the practice and application of recognized prevention strategies.

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1.52 **Risk and Protective Factor Framework for Prevention** refers to a theory underlying state and federal service delivery systems. The Risk and Protective Factor framework identifies the underlying conditions contributing to or associated with a specific problem behavior or a set of problem behaviors, and the conditions which reduce the likelihood that these problem behaviors will occur.

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1.53 **Risk Factor** refers to a condition that increases the likelihood of **ATOD** use.

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1.53.1 **At-Risk** refers to those individuals, families, and communities in need of a preventive intervention so as to reduce or prevent the likelihood of their involvement in illegal or age inappropriate behavior concerning alcohol, tobacco or other drugs.

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1.53.2 **High Risk** refers to individuals who are exposed to or experimenting with alcohol, tobacco, or other drugs and who possess multiple risk factors for substance abuse.

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1.54 **SAPTBG** refers to the Substance Abuse Prevention and Treatment Block Grant.

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1.55 **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.

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1.56 **Service Population** refers to a specific group or population to which prevention programs and activities are provided.

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1.57 **Shall** means that an obligation to act is imposed.

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1.58 **Single Prevention Service** refers to the provision of a single, one-time prevention service or event.

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1.59 **Staff** refers to any employee, intern, trainee, independent contractor, or volunteer performing a service or activity for the organization and for meeting the needs of the individuals served for which competent performance is expected.

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1.60 **Structure** refers to those attributes that provide a framework for program activities and content based on identified needs and recognized prevention and early intervention approaches.

1.61 **Substance Abuse Prevention Principles** refers to basic truths, standards and elements that effective interventions have in common and that have been identified through the careful evaluation of substance abuse prevention programs. Principles derive from programs and are best used to modify or adapt program core philosophy and content to specific situations or populations.

1.62 **Technical Assistance** refers to the provision of expert advice, skilled training, and general technical support to organizations and entities within and outside of the specialized substance abuse service system**.**

1.63 **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.

1.64 **Variance Process** means the process delineated in the duly promulgated Rules and Regulations for Licensing Procedure and Process for Facilities and Programs Licensed by the Department of Mental Health, Retardation and Hospitals. This specifically refers to the requirements contained in these Standards.

1.65 **Volunteer,** for the purposes of these standards, refers to an individual performing a service or activity for an organization who does not receive compensation for services or activities provided.

1.66 **Workforce Development** refers to the implementation of policies and procedures to enable prevention organizations to recognize and foster the knowledge, skills, abilities and attitudes necessary to effectively practice alcohol, tobacco, and other drug abuse prevention service delivery.

Section 2.0: General Requirements

Each organization funded by the Department of MHRH to provide prevention services in the State of Rhode Island shall meet the following general prevention standards:

2.1 Primary outcomes are identified for each prevention service provided by the organization;

2.2 The leadership of the organization reinforces Department of MHRH-adopted prevention principles/practices and standards;

2.3 Policies and procedures of the organization are compatible with prevention standards;

2.4 The organization provides training opportunities to improve knowledge, attitudes, and skills necessary for all staff to conduct evidence-based prevention services.

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Section 3.0: Monitoring and Auditing

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The Department shall make or cause to be made such inspections and investigations that it deems necessary in accordance with the certification standards and any other applicable Department rules and regulations.

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3.1 Authorized personnel from the Department shall have free access to the grounds, buildings, and all books and records relating to any organization certified by the Department.

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3.2 The Department shall be entitled to receive from any MHRH certified organization, information and assistance as may be required by the Director to conduct an examination or inquiry.

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Section 4.0 Certification Actions

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Failure to comply with these Certification Standards and/or failure to comply with any applicable Department rules and regulations shall permit the Director to take appropriate action from within the following array of sanctions:

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4.1 An immediate compliance order may be issued to an organization if the Director determines that immediate action is necessary to protect the health, welfare or safety of participants, staff, and/or the general public.

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4.2 The Department may curtail, limit, suspend, place on conditional status, or revoke the certification of the organization.

4.2.2 A limited or conditional prevention certification may be issued to an organization that has demonstrated an inability to maintain compliance with these Standards, with other Departmental rules or regulations, and/or with any applicable state or federal statute or rules or regulations; has demonstrated conduct or practice found by the Director to be detrimental to the welfare of persons served by the organization; or has failed to comply with a previous plan of correction.

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4.2.3 If it is determined that revocation of an existing certification would not be in the best interests of persons served by the organization, or in the best interests of the community served by the organization, the Director shall list the requirements with which the organization must comply in order to receive a limited or conditional prevention contract in lieu of revocation.

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4.3 A non-recoverable financial penalty may be imposed for violations of these Standards; with other applicable Departmental rules and regulations; or with any applicable state or federal statute or regulation.

Section 5.0: Deficiencies and Plans of Correction

The Department shall notify the legal authority of the organization of violations of these Standard(s), or other applicable Department rules and regulations, through a notice of deficiencies which shall be forwarded to the organization, unless the Director determines that immediate action is necessary to protect the health, welfare, or safety of participants, staff, and/or the general public through the issuance of an immediate compliance order.

5.1 An organization that receives a notice of deficiencies must submit a plan of correction, to include time frames for completion, to the Department within thirty (30) days of the date of the notice of deficiencies. The plan of correction may detail any requests for variances as well as document the reasons therefore.

5.1.1 An extension for submission of a plan of correction may be requested in writing to the Department.

5.2 The Department may subsequently request an amended plan of correction. The amended plan of correction must be resubmitted to the Department within ten (10) business days of the date of the organization's receipt of the request for an amended plan of correction.

5.3 If the Department rejects the plan of correction, or if the certified organization does not provide a plan of correction within the thirty (30) day period stipulated in section 5.1 above, or if an organization whose plan of correction has been approved by the Department fails to execute its plan within a reasonable time, as determined by the Department, the Department may invoke one or more sanctions as enumerated in sections 4.2 and 4.3 above.

5.4 If the organization is aggrieved by the action of the Department, the organization may appeal the decision and request a hearing in accordance with Rhode Island General Laws §42-35-1 *et seq*.

5.4.1 The notice of hearing to be given by the Department shall comply in all respects with the provisions of Rhode Island General Laws §42-35-1 *et seq*. The hearing shall in all respects comply with the provisions therein.

Section 6.0 Reports of Deficiencies

6.1 Reports of deficiencies noted in inspections conducted in accordance with these Standards and other applicable rules and regulations, and the results of any Departmental

investigation, and plans of correction as described herein, shall be maintained on file at the Department and shall be considered by the Department in rendering determinations to deny, condition, limit, suspend or revoke any or all prevention certification(s) of the organization.

Section 7.0: Variance Procedures

7.1 The Department may within its discretion, and for good reason, grant a variance to a specific requirement contained in these standards. A variance will be granted only when the Department determines that the health, safety or welfare of individuals or the quality of services to individuals is not adversely affected. The Department reserves the right to revoke a variance if the conditions required by the variance are not met.

7.2 An organization may submit a request for a variance in writing to the Department. Such request shall include a specific reference to the section of the standards for which a variance is sought, a full explanation of why the variance is necessary, and a full explanation of alternative provisions or procedures proposed by the organization.

7.3 The Department must approve a variance prior to implementation. A variance may be time limited. A variance may have other attached conditions or stipulations.

7.4 The organization may request a renewal of the variance from the Department. Such request shall be made at least 30 days prior to the expiration of the current variance.

7.5 Within thirty (30) days of the receipt of the variance request, unless additional time is required, the Department shall review the request and return a decision, in writing, to the applicant.

7.6 No provisions or procedures prescribed by state or federal statute shall be waived.

Section 8.0 Rules Governing Practices and Procedures

8.1 All hearings and reviews required pursuant to these standards shall be held in accordance with the provisions of Rhode Island General Laws §42-35-1 *et seq*. and the Department's applicable Rules and Regulations.

Part II Organization and Management

Section 9.0: Leadership and Organization Planning

9.1 The goal of the leadership function is to improve services, as well as to identify desired outcomes, through effective leadership and management. The organization's leaders must demonstrate a commitment to organizational quality and to service excellence, and responsiveness to individual and community needs.

9.2 The organization shall operate in accordance with all applicable local, state and federal laws, rules, and regulations.

9.3 Each organization shall have an organized Board of Directors, or in the case of municipal task forces, a municipal representative acting as the fiduciary agent for Rhode Island Substance Abuse Prevention Act funding, which/who is responsible for:

9.3.1 Program and fiscal management and operation of the organization

9.3.2 Assurance of the quality of prevention services; and

9.3.3 Compliance with all federal, state, and local laws, and regulations pertaining to behavioral health prevention services, and the standards herein.

9.4 The membership of RISAPA task forces shall, at a minimum, include those representatives specified in Rhode Island General Laws §16-21.2.

9.5 The Board of Directors shall adopt by-laws, or follow applicable provisions of the respective municipal charter, defining ethical standards and responsibilities for the operation and performance of the organization.

9.6 The leaders of the organization shall provide for organizational planning.

9.7 An annual written plan shall define the strategic, operational, and program-related outcome objectives of the organization.

9.8 Leadership shall develop, maintain, and provide evidence of:

9.8.1 policies that evidence compliance with ADA requirements;

9.8.2 policies and procedures to comply with these standards.

9.9 The leaders shall communicate the organization's mission, vision, values and plan to all staff of the organization as well as to the population served.

9.10 The written plan for services shall be consistent with evidence-based and recognized best practice standards and guidelines where available and as applicable.

9.11 The leaders shall develop strategies to promote staff recruitment, retention, development and continuing education.

Section 10.0 Financial Management

10.1 The Board of Directors of an organization having been certified by the Department to provide prevention services, or in the case of municipal task forces, the municipality acting as fiduciary agent for RISAPA funding, shall develop and submit to the Department for review and approval, an annual operating budget for use of funds received from the Department.

10.2 The Board of Directors, or in the case of the municipal task forces, the voting members of the task force, shall approve the annual operating budget for use of funds received from the Department prior to submission to the Department for its review and approval.

10.3 At its discretion, the Department may require periodic independent certified audits of expenditures, of funds received from the Department, made by an organization certified by the Department.

Section 11.0: Direction of Services

11.1 The leadership of the organization promotes the prevention standards defined herein.

11.2 The leadership of each program or service is responsible for developing and implementing policies and procedures that guide the provision of prevention services.

11.3 The leadership of each organization is responsible for orientation, and opportunities for training of all staff in the program or service.

11.4 The leadership of each organization is responsible for verifying the certification of prevention service staff, if applicable.

Section 12.0: Role of Leadership in Performance Improvement

12.1 The leadership is responsible for ensuring that processes and activities most important to prevention outcomes are continuously and systematically measured, assessed, and improved throughout the organization.

12.2 The organization shall assign in writing responsibility for acting on performance improvement recommendations.

Section 13.0: Human Resources

13.1 The organization recruits, manages, and retains personnel who support and promote the mission of the organization and reflect the community it serves. The goal of the human resources management function is to create an environment that fosters self-development and continued learning to support provision of the highest quality prevention services.

13.2 Leadership shall define the qualifications and competencies of staff in accordance with these standards.

13.3 Leadership shall determine and provide an adequate number of staff whose qualifications are consistent with job responsibilities and the needs of persons served.

13.4 The organization shall recruit personnel who reflect the cultural diversity of the community/communities in which the organization provides services.

Section 14.0: Staffing and Staff Qualifications

14.1 Prior to employment, the organization shall obtain and maintain documentation of:

14.1.1 Verification of the person's education and training;

14.1.2 Verification of the person's current certification status;

14.1.3 Evidence of the person's knowledge and experience for assigned responsibilities;

14.1.4 A copy of the person's current Bureau of Criminal Identification Record and Rhode Island's Child Abuse and Neglect Tracking System (CANTS) check in compliance with MHRH Rules and Regulations for Employee Criminal Records Check.

A. In the event that a person's Bureau of Criminal Investigation (BCI) and/or CANTS report contains disqualifying information, the Board of Directors, or in the case of municipal task forces, an authorized municipal representative, shall make and document a judgment regarding the employment of the perspective employee. Such judgment shall be based on consideration by the Board of Directors or authorized municipal representative of whether the disqualifying information indicates that the employment could endanger the health or welfare of persons served by the organization.

14.1.5 The organization shall have a policy that requires employees to report to the organization any changes in the status of his/her BCI and/or CANTS record subsequent to their hire by the organization.

14.2 Individuals employed to provide prevention services (including subcontractors) shall meet the minimum standards for a Certified Prevention Specialist in accordance with

criteria established by the Rhode Island Board for Certification of Chemical Dependency Professionals within three calendar years from the date of Standards promulgation or from their date of hire, whichever is most recent.

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14.3 Organizations conducting prevention services shall provide for an initial orientation within 30 days of employment and documentation of such shall be made available to the MHRH monitoring team. The orientation shall include at a minimum:

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14.3.1 Acquainting staff with policies and procedures, expected codes of conduct, and expected practices for prevention staff including use of current prevention concepts and program strategies, theory, research, and best practices findings upon which prevention services and programs of the agency are based;

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14.3.2 When appropriate, the confidentiality of participant information, including a review of 42 CFR, Part II, the Health Insurance Portability and Accountability Act (HIPAA) and ADA requirements. The organization shall advise staff as to all applicable state and federal laws, rules and regulations, including reporting child abuse/neglect or misconduct by individuals or agencies. The organization has the responsibility to be aware of and maintain compliance with all applicable state and federal guidelines, regulations, statutes and agency policies regarding confidentiality, data privacy, and professional relationships.

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14.3.3 The proper maintenance and handling of participant program records;

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14.3.4 Procedures to follow in the event of a medical emergency or natural disaster; and

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14.3.5 The employee's specific job description and job responsibilities.

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14.4 The organization shall maintain and annually update a description of its staffing pattern, including an organizational chart showing lines of authority for prevention services.

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14.5 The organization shall also document efforts made to ensure the cultural competence of staff providing prevention services as well as the efforts made to ensure that culturallyappropriate prevention services are implemented and provide such to the MHRH monitoring team.

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14.6 The organization shall develop and document criteria for the qualification of individuals employed as volunteers and for individuals employed as consultants to provide a specific and defined prevention service(s).

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14.7 The competence of staff members to provide contracted prevention services shall be continuously assessed, maintained, demonstrated, and improved.

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14.8 The organization shall have a mechanism for receiving regular feedback from staff to help create an environment that promotes self-development and learning

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14.9 If the organization uses volunteers, trainees, consultants, or interns to provide direct substance abuse prevention services, these individuals must:

14.9.1 Receive appropriate training and supervision consistent with programmatic requirements;

14.9.2 Be provided with information concerning liability insurance coverage;

14.9.3 Be informed of any personal risks or liabilities;

14.9.4 Undergo a Bureau of Criminal Identification Record check in compliance with MHRH Rules and Regulations for Employee Criminal Records Check.

14.9.5 If working directly with underage individuals, undergo a CANTS check.

Section 15.0: Prevention Staff Workforce Development

15.1 Organizations shall offer all Departmentally funded prevention staff the opportunity to attend a minimum number of required hours in theory, research and best practices for prevention services as prescribed by the Division and prevention certification requirements.

15.2 Professional development may include a combination of agency based in-service training and off-site training.

15.3 All professional development, including evidence of progress in obtaining prevention certification, shall be documented in personnel records and shall be made available to authorized personnel from the Department upon request.

Section 16.0: Management of the Environment of Service Provision

16.2 The organization shall plan for and provide a safe, accessible, effective, and efficient environment for staff and persons served consistent with its mission, services, and applicable federal, state, and local laws, codes, rules, and regulations (including but not limited to the Americans with Disabilities Act).

16.2.1 Safety policies and procedures shall be distributed, practiced, and enforced.

16.4 Use of alcohol and tobacco products shall be prohibited at all sites and/or areas where prevention services are provided.

16.5 The organization shall develop and implement an emergency management plan.

16.6 Staff providing direct prevention services shall be made aware of emergency management procedures in any facility where prevention services are being offered.

Part III Description of Common Prevention Program Operating Standards

All programs providing Primary Prevention services in Rhode Island shall abide by the following Common Operating Standards:

Section 17.0: Purpose and Scope of Prevention Programs

17.1 Prevention services shall be provided for the general public, including children, youth, and adults who may be at risk for substance abuse, but who are not necessarily in need of treatment services.

17.2 Prevention services shall encompass current research, theory, and practice-based strategies and activities implemented through structured prevention services to those not in need of ATOD-related treatment services. These services are intended to preclude, forestall, or impede the development of alcohol, tobacco, and other drug abuse or misuse and their associated health and social consequences.

17.3 Services shall be provided along the prevention continuum that identifies universal, selected, and indicated preventive interventions (IOM model). These interventions require that prevention services be respectively tailored appropriately to persons at average risk of a substance abuse disorder, persons at significantly greater than average risk for a substance abuse disorder, and persons who may be displaying early signs and symptoms of a disorder or who carry biological markers for an alcohol, tobacco, and other drug abuse disorder.

17.4 Organizations shall have the capability to provide and shall provide one (1) or more prevention services as defined under current CSAP-designated prevention strategies.

17.5 The selection, design and delivery of services shall be based on the results of current needs assessment.

~~17.6 Prevention services shall be selected, developed, implemented and evaluated consistent with prevention principles as defined by the National Institute on Drug Abuse (NIDA).~~

~~17.7 Organizations receiving funding through the federal Safe and Drug-Free Schools and Communities Act shall adhere to the Principles of Effectiveness as defined by the U. S. Department of Education.~~

~~17.8 Each organization that conducts classroom or group educational programs shall use a structured curriculum for prevention education; based on current alcohol, tobacco, and other drug abuse research and best practice findings.~~

~~17.9 Organizations shall use and make available current, culturally relevant, and age-appropriate, written materials including, but not limited to, brochures, pamphlets, newsletters, and other appropriate print materials intended to inform individuals, families, schools, and communities about the nature and scope of ATOD use including primary prevention, intervention, and treatment services;~~

~~17.10 As appropriate, organizations shall utilize risk screening and assessment tools to determine appropriate placement in prevention services or in other community services as needed.~~

~~17.11 Organizations conducting student assistance programs (SAP) shall provide services to youth who have alcoholic or other drug abusing parents; youth who have been abusing alcohol, or other drugs but whose use does not meet current DSM criteria for addiction; youth who have been using tobacco; and youth who may have behavioral, academic, and/or family problems that may dispose them to ATOD abuse.~~

~~17.11.1 Individuals employed in student assistance services shall meet the State's requirements for professional experience as determined by the requirements for a Certified Student Assistance Counselor.~~

~~17.11.2 Organizations conducting student assistance programs shall maintain appropriate policies and procedures for the referral of students needing assistance beyond the capability of the SAP program; such referrals shall be documented in program records.~~

~~17.12 Organizations providing services to educate or inform vendors of alcohol or tobacco products relative to sale of such to minors, shall provide a structured educational program, approved by the Department, intended to reduce the sale of alcohol or tobacco products to underage youth.~~

~~17.13 Organizations providing public policy campaigns intended to impact environmental efforts shall develop such campaigns to reflect current prevention theory, research, and best practices.~~

Section 18.0: Defined Program Content

18.1 Each organization providing Primary Prevention services shall delineate the scope of services to be offered within an annual program service plan. Such scope of services for prevention programs shall be approved by the organization's Board of Directors or membership, and approval shall be documented in Board or Membership Meeting Minutes.

18.2 Each organization shall demonstrate within the annual program service plan:

18.2.1 knowledge and understanding of the risk and protective factors that relate to substance abuse;

18.2.2 knowledge of prevention principles; and for organizations receiving Safe and Drug-Free Schools and Communities funding, knowledge of current federal Department of Education's Principles of Effectiveness;

18.2.3 documentation of the extent of the problem behavior(s) within the target population or community, including the review and assessment of available local social indicator data;

18.2.4 documentation of assessment of risk and protective factors within the target population or community, including the review and assessment of available local social indicator data;

18.2.5 knowledge of potential prevention strategies and rationale for selection of strategies to be implemented;

18.2.6 the ability to make those strategies most effective for prevention program participants, including knowledge of fidelity and adaptation issues;

18.2.7 the ability to utilize core measures in the evaluation of the strategies to be implemented.

18.3 Program service plans shall include a logic model based on guidance provided by the Division.

18.4 Each organization shall provide to the Division, maintain, and annually update, a Program Service Plan which includes a description of the following:

18.4.1 Problem Statement (based on results of a documented needs assessment);

18.4.2 Target Service Population(s);

18.4.3 Measurable outcome objectives

18.4.4 Measurable intermediate objectives;

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18.4.5 Specific Primary Prevention Strategies to be employed in providing primary prevention services;

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18.4.6 Process and Outcome Evaluation, including an assessment of progress in achieving intended outcomes, and identification of the measures and instruments to be utilized in conducting the process and outcome evaluation.

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Section 19.0: Referral Resource.

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19.1 Each organization shall maintain or demonstrate access to a current database of information and referral resources on ATOD, substance abuse services, and prevention and treatment resources for their community or service area. Such information shall, at a minimum, be made available upon request.

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Section 20.0: Record of Activities.

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20.1 Each organization conducting prevention services shall maintain a record of all prevention activities provided in accordance with the described program content. In addition, each organization shall provide a description of how activities provided meet the specific needs of the individual, group or community organization served. Records shall, at a minimum, include but are not limited to:

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20.1.1 Record of presenters and participants involved in Primary Prevention services; date(s) of presentations or service provision;

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20.1.2 Number of participants and the demographic characteristics of participants, including but not limited to:

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A. age;
B. race/ethnicity;
C. gender;
D. service population; and
E. such other information as may be requested by the Division.

20.1.3 Consent for participation or for release of information, if needed;

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20.1.4 Record of all program topics and activities;

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20.1.5 Copies of programmatic materials;

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20.1.6 Other prevention management information;

20.1.7 Copies of program evaluations.

20.2 A record shall be kept on any individual receiving selective or indicated prevention services from a certified organization.

20.3 Each record shall contain, at a minimum, the following information:

20.3.1 The individual's

A. Name
B. Address
C. Date of Birth
D. Gender
E. Race or Ethnic Origin
F. Name and Phone Number of any legally-authorized representative
G. Information regarding the person to contact in an emergency, including the person's name, address and phone number H. Evidence of informed consent, as appropriate
I. Documentation of individual, family or guardian consent for all services, refusal to consent, or withdrawal of consent
J. Documentation of any referrals made to external or internal service providers and community agencies, including information regarding services provided to that individual

20.4 Every record kept on an individual receiving selective or indicated prevention services shall be dated and signed by the author's full name and credentials.

20.5 Unless otherwise required under applicable state regulation or statute, the record of any adult individual provided selective or indicated prevention services, including but not limited to, assessment and referral, shall be maintained for a minimum of six (6) years

post discharge from the organization's services. The records of minors who have received selective or indicated prevention services shall be maintained for a minimum of six (6) years after the date when he/she reaches age eighteen (18).

20.6 In the event the organization ceases operation, the organization shall maintain and enforce a written policy regarding proper transfer or disposal of records consistent with local, state, and federal statutes, rules, and regulations.

Section 21.0 Management Information System

The goal of the information management function is to collect, manage, and use information to improve individual and organizational performance in service delivery, governance, management, and support processes.

21.1 The organization shall develop and implement an information management process to meet internal and external information needs.

21.2 The organization shall have and maintain the ability to report data in an electronic fashion to the Department for such purposes as the Department deems necessary, or as is required by other funding or oversight entities.

21.3 The organization shall establish and maintain records and electronic data in such a manner as to make uniform the system of periodic reporting required by the Department. The manner in which the requirements of the standard may be met shall be prescribed by the Department.

21.4 The organization shall provide all requested information, either routine or non-routine as specified by the Department.

21.5 All information and data shall be collected, maintained, and transmitted to the Department in a manner consistent with state and federal privacy and confidentiality statutes and regulations, including those standards and requirements stipulated by the Health Insurance Portability and Accountability Act (HIPPA).

21.5.1 Access to information shall be based on need and defined by job title and function.

21.5.2 Only authorized individuals shall make entries into a program participant's record as specified in the organization's policies.

21.6 The organization shall maintain a record of a participant's informed consent to participate in a prevention program or initiative; or in the case of a minor, the informed consent of a parent or legal guardian, where applicable.

21.7 The organization shall maintain a written record for each individual of any referrals or communications made to external or internal care providers.

21.8 Records and information shall be protected against loss, destruction, tampering, and unauthorized access or use.

Section 22.0 Confidentiality

22.1 All persons served by the organization have the right to have their personal records kept confidential pursuant to the applicable federal and state statutes and regulations.

22.1.1 The organization shall at all times protect the privacy of persons served and shall comply with all the requirements of the applicable state and federal confidentiality statutes and regulations.

22.1.2 Each organization shall develop policies and procedures in accordance with all state and federal statutes and regulations with respect to the privacy and confidentiality of the records and identity of persons served.

22.2 The organization shall provide training for all staff on its policies and procedures with respect to the privacy and confidentiality of client-specific records and health care information.

22.3 An organization's violation of any state or federal confidentiality statute, rule, or regulation may result in a certification action by the Department.

Section 23.0 Research

23.1 In the event that research, experimentation, or clinical trials involving human subjects is to be conducted, the organization must adhere to all applicable state and federal statutes, rules, and regulations.

23.2 If the research is proposed in conjunction with a university or college, the organization is required to provide documentation verifying that the research has been reviewed by the university's/college's human subjects review board (IRB).

Section 24.0: Performance Improvement

24.1 Each organization shall develop and implement an annual prevention performance improvement plan that:

24.1.1 identifies the organization's performance goals and priorities for the year;
24.1.2 uses performance measures and data collection to monitor performance and identifies and prioritizes opportunities for improvement;
24.1.3 addresses adherence to these prevention certification standards;
24.1.4 addresses such other requirements as may be determined by the Department.

24.2 Organizations shall evaluate the effectiveness of their services, utilizing criteria and tools such as:

24.2.1 participant evaluations;

24.2.2 program service plans;

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~~24.2.3 program evaluation;~~

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~~24.2.4 annual program reports;~~

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~~24.2.5 core measures;~~

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~~24.2.6 knowledge of resources and services;~~

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~~24.2.6 other measures acceptable to the Department.~~

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~~24.3 Program evaluation shall include the development and reporting of intermediate and outcome measures related to demonstration of reductions in risk factors, increases in protective factors and individual and/or community behavioral change.~~

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